### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2015

This Form is Open to Public Inspection

						inspection	
Part I		entification Information					
For caler	ndar plan year 2015 or fisca	al plan year beginning 01/01/2015		and ending 12/31/2015	5		
A This r	eturn/report is for:	a multiemployer plan;		oloyer plan (Filers checking this mployer information in accorda			ns); or
		x a single-employer plan;	a DFE (specify	<i>'</i> )			
<b>B</b> This return/report is: ☐ the first return/report; ☐ the final return/report;							
	·	an amended return/report;	a short plan ye	ear return/report (less than 12 n	nonths).		
C If the	plan is a collectively-barga	ined plan, check here					
<b>D</b> Check	k box if filing under:	X Form 5558;	automatic exter	nsion;	the	DFVC program;	
		special extension (enter description)	)				
Part I	I Basic Plan Info	rmation—enter all requested informa	ation				
1a Nam		HOPAEDICS, P.S.C. 401(K) PROFIT S	SHARING PLAN			Three-digit plan number (PN) ▶	001
						Effective date of pla 02/01/1969	an
		r, if for a single-employer plan) apt., suite no. and street, or P.O. Box)				Employer Identifica Number (EIN)	tion
City	or town, state or province,	country, and ZIP or foreign postal code	(if foreign, see instr	uctions)		61-0678573	
ELLIS, BA	ADENHAUSEN ORTHOPA	EDICS, P.S.C.				2c Plan Sponsor's telephone number	
					24	502-587-1236	
	AGISTERIAL DRIVE, SUIT LLE, KY 40223-4103		GISTERIAL DRIVE, LE, KY 40223-4103	SUITE 200		Business code (see instructions) 621111	9
Caution:	A penalty for the late or	incomplete filing of this return/repor	t will be assessed	unless reasonable cause is e	establis	hed.	
		r penalties set forth in the instructions, I Il as the electronic version of this return					
SIGN HERE	Filed with authorized/valid	electronic signature.	08/24/2016	R. JOHN ELLIS			
TILKE	Signature of plan admin	istrator	Date	Enter name of individual sign	ning as p	olan administrator	
SIGN							
HERE	Signature of employer/p	alan enoneor	Date	Enter name of individual sign	nina as e	amployer or plan spe	onsor
	Signature of employer/p	nan sponsor	Date	Enter name of individual sign	iiig as c	employer or plair spi	011301
SIGN							
HERE	Signature of DFE		Date	Enter name of individual sign	ning as F	)FF	
Preparer	•	ne, if applicable) and address (include r				elephone number	

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	Plan administrator's name and address Same as Plan Sponsor LIS AND BADENHAUSEN ORTHOPAEDICS, P.S.C.			inistrator's EIN 61-0678573
	151 MAGISTERIAL DRIVE, SUITE 200 UISVILLE, KY 40223-4103		num	inistrator's telephone ber 502-587-1236
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5	106
6	Number of participants as of the end of the plan year unless otherwise states <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	d (welfare plans complete only lines 6a(1),		
a(′	1) Total number of active participants at the beginning of the plan year		6a(1)	82
a(2	2) Total number of active participants at the end of the plan year		6a(2)	84
b	Retired or separated participants receiving benefits		. 6b	1
С	Other retired or separated participants entitled to future benefits		. 6c	21
d	Subtotal. Add lines 6a(2), 6b, and 6c.		. 6d	106
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	. 6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>		. 6f	106
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g	95
	Number of participants that terminated employment during the plan year with less than 100% vested		. 6h	3
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature co 2E 2H 2J  If the plan provides welfare benefits, enter the applicable welfare feature cod	les from the List of Plan Characteristics Code	s in the ins	
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all the	at apply)	
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1) Insurance Code section 412(e)(3)	ingurance	contracts
	(3) X Trust	(3) X Trust	modranoc	Contracts
	(4) General assets of the sponsor	(4) General assets of the s	ponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	· — —	ber attache	ed. (See instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) X I (Financial Inform (3) X 1 A (Insurance Inform (4) C (Service Provide	rmation) er Informat	ion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participation (6) G (Financial Trans	-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Yes" is	checked, complete lines 11b and 11c.					
11b Is the plar	n currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)						
Receipt C	confirmation Code					

Form 5500 (2015)

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# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015					•		
A Name of plan				B Three-digit			
ELLIS AND BADENHAUS	SEN ORTHOPA	EDICS, P.S.C. 401(K) PROFIT	SHARING PLAN	plan	number (PN)	001	
C Plan sponsor's name a	as shown on line	2a of Form 5500		<b>D</b> Emplo	oyer Identification Number (	(EIN)	
ELLIS, BADENHAUSEN (	ELLIS, BADENHAUSEN ORTHOPAEDICS, P.S.C. 61-0678573						
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of incurance of							
(a) Name of insurance ca JOHN HANCOCK LIFE IN:		MDANV					
JOHN HANGOOK EH E HA	OUTAINOL OUI	WII ZANT					
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
01-0233346	65838			)	01/01/2015	12/31/2015	
2 Insurance fee and com descending order of the		ition. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents, brokers, and o	ther persons in	
	amount of comm	nissions naid		(b) T	otal amount of fees paid		
(a) Total a	amount of comi	13083		(6)	otal amount of ices paid	0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	nercone)			
3 Tersons receiving com		nd address of the agent, broker,			sions or fees were paid		
HILLIARD LYONS INSURA			OX 32760		None of 1000 Word Para		
		LOUIS	VILLE, KY 40232-2760				
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code	
	13083					4	
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	sions or fees were paid		
(b) Amount of sales ar	ad base	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	
				•			
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, se	a the instructions for l	Form 5500			
. or i aportroit iteauctio	AUL HULIUG A			J JJJ00	0-1	I. I. A (F FFOO) 004F	

Page <b>2 -</b> 1	
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<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	<del>-</del>	·	
		Fees and other commissions paid	
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) No	me and address of the agent broke	r or other person to whom commissions or foca were poid	
(a) Na	ine and address of the agent, broke	r, or other person to whom commissions or fees were paid	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•	•	, , ,	
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
			•
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	(-)	727	

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ay		•

7f

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrie	er may be treated as	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
		(6)Total additions			7c(6)	0
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	0

**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**).....

Schedule A (Form 5500) 2015	Page <b>4</b>
Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contract the entire group of such individual contracts with each carrier may be	the same employer(s) or members of the same employee organizations(s), the cts are experience-rated as a unit. Where contracts cover individual employees, be treated as a unit for purposes of this report.
nefit and contract type (check all applicable boxes)	
Health (other than dental or vision) <b>b</b> Dental	<b>c</b>
Temporary disability (accident and sickness) <b>f</b> Long-term disa	ability $\mathbf{g} \ \square$ Supplemental unemployment $\mathbf{h} \ \square$ Prescription drug
Stop loss (large deductible) j	k ☐ PPO contract I ☐ Indemnity contract
Other (specify)	
erience-rated contracts:	
Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	9a(2)
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	9b(1)
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	9b(3)
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	9c(1)(B)
(C) Other specific acquisition costs	9c(1)(C)
(D) Other expenses	9c(1)(D)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

**10** Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid......

(E) Taxes..... (F) Charges for risks or other contingencies .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) ......

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(E)

9c(1)(F)

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

### SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation s schodule is required to be filed under section 104 of the Employee

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

Financial Information—Small Plan

File as an attachment to Form 5500.

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015		and ending	12/3	1/2015	
A Name of plan ELLIS AND BADENHAUSEN ORTHOPAEDICS, P.S.C. 401(K) PROFIT SHARING PLAN	В	Three-digit plan number (I	PN)	<b>)</b>	001
C Plan sponsor's name as shown on line 2a of Form 5500 ELLIS, BADENHAUSEN ORTHOPAEDICS, P.S.C.	D	Employer Identi 61-0678573	ificatio	n Numbe	er (EIN)

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

#### Part I | Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

1	Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
а	Total plan assets	. 1a	23208365	23216659
b	Total plan liabilities	. 1b		
С	Net plan assets (subtract line 1b from line 1a)	1c	23208365	23216659
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	<b>(b)</b> Total
а	Contributions received or receivable:			
	(1) Employers	. 2a(1)	593168	
	(2) Participants	. 2a(2)	348356	
	(3) Others (including rollovers)	. 2a(3)		
b	Noncash contributions	. 2b		
С	Other income	. 2c	-228141	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	. 2d		713383
е	Benefits paid (including direct rollovers)	. 2e	635424	
f	Corrective distributions (see instructions)	. 2f		
g	Certain deemed distributions of participant loans (see instructions)	. 2g		
h	Administrative service providers (salaries, fees, and commissions)	. 2h	69665	
i	Other expenses	. 2i		
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		705089
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		8294
	Transfers to (from) the plan (see instructions)	. 2I		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
а	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	
	Real estate (other than employer real property)			Χ	
d	Employer securities	3d		X	
	Participant loans		X		29425

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Schedule I (For	m 5500) 201:	5
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				Yes	No	Δ	mount
3f	Loans (other than to participants)		3f	103	X		mount
g	Tangible personal property	F	3g		X		
Pa	art II Compliance Questions						
4	During the plan year:		Yes	No	N/A	Δ	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? Continue to answer "Yes" for any prior year failures until fully	4a	163	X	IVA		mount
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by	4b		X			
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X			
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X			
е	Was the plan covered by a fidelity bond?	4e	Х				500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X			
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X			
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X			
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X			
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X			
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X				
ı		41		X			
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		X			
0	Did the plan trust incur unrelated business taxable income?	40					
р	Were in-service distributions made during the plan year?	4p					
÷	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?  If "Yes," enter the amount of any plan assets that reverted to the employer this year		Yes	s XN	o A	Amount:	
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), transferred. (See instructions.)	, ide	ntify th	ne plan	(s) to w	hich assets or	liabilities were
	5b(1) Name of plan(s)				5b(2)	EIN(s)	<b>5b(3)</b> PN(s)
5c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA	sec	tion 40	)21)?	📗 Y	'es No	Not determined

Part III	Trust Information	
6a Name o	of trust	6b Trust's EIN
6c Name o	of trustee or custodian	6d Trustee's or custodian's telephone number

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210 - 0110 1210 - 0089

2015

This Form is Open to Public Inspection

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) ELLIS , BADENHAUSEN ORTHOPAEDICS , P.S.C.  2b Employer identification Number (E 61–0678573 2c Plan Sponsor's telephone number (502–587–1236 2d Business code (see instructions) 621111  LOUISVILLE KY 40223 – 4103  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established	Part	Annual Report Identific	ation Informati	on				100
A This return/report is for:    a multiemployer plan;   a multiemployer plan;   the first return/report;   a single employer plan;   the first return/report;   an amended return/report;   and return/report;   an amended return/report;   an amended return/report;   an amended return/report;   and return/report;   and return/report;   an amended return/report;   an			year beginning	01/01/20	15	and ending	12/31/2015	
the first return/report is:  If the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained plan, check here  Created by the plan is a collectively-bargained blank plan in the plan into	A This	return/report is for: a multie	mployer plan;				checking this box must att	
C if the plan is a collectively-bargained plan, check here  D Check box if filing under:  X Form 5558; Special extension (enter description)  Part II Basic Plan Information - enter all requested information  1a Name or plan  ELLIS AND BADENHAUSEN ORTHOPAEDICS, P.S.C.  401 (K) PROPIT SHARING PLAN  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 Typ of reging postal code (if foreign, see instructions)  ELLIS, BADENHAUSEN ORTHOPAEDICS, P.S.C.  13151 MAGISTERIAL DRIVE, SUITE 200  LOUISVILLE  KY 40223 - 4103  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Proparer's name (including firm name, if applicable) and address (include room or suite number)  Signature of employer/plan sponsor  SIGN  HERE  Signature of employer/plan sponsor  Date  Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Paragraphy of the flate of including firm name, if applicable) and address (include room or suite number)  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's name (including firm name, if applicable) and address (include room or suite number)	<b>B</b> This	return/report is: the first	return/report;	the fin	nal return	/report;	less than 12 months)	
D Check box if filing under:	C If the				r pian yo	ar rotarrizoport (i	loss triair 12 montris).	
Basic Plan Information - enter all requested information  1a Name of plan   ELLIS AND BADENHAUSEN ORTHOPAEDICS   P.S.C.		ck box if filing under:	558;	autom	atic exte	nsion;	the DFVC program;	
1a Name of plan ELLIS AND BADENHAUSEN ORTHOPAEDICS , P.S.C.  1b Three-digit plan number (PN) ▶ 001  1c Effective date of plan 02/01/1969  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) ELLIS , BADENHAUSEN ORTHOPAEDICS , P.S.C.  2b Employer Identification Number (Ed. 10-0678573 2c Plan Sponsor's telephone number (S02-587-1236 2d Business code (see instructions) 6211111  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filling of this return/report, including accompanying schedules, statements and attachments, as we see section where penalties and penalties of penips and other penalties of penips and	Part I	Basic Plan Information	enter all requested	information				
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) ELLIS, BADENHAUSEN ORTHOPAEDICS, P.S.C.  20 Plan sponsor's telephone number 502-587-1236 2d Business code (see instructions) 621111  LOUISVILLE KY 40223-4103  Caution: A penalty for the late or incomplete filing of this return/ eport will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/ eport will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/ eport will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/ eport will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/ eport, and complete.  Caution: A penalty for the late or incomplete filing of this return/ eport will be assessed unless reasonable cause is established.  Caution: A penalty for the late or incomplete filing of this return/ eport, and complete.  Caution: A penalty for the late or incomplete filing of this return/ eport, including accompanying schedules, statements and attachments, as we as the electronic version of this return/eport, and to the best of my knowledge and belief, it is true, correct, and complete.  Signal R. JOHN ELLIS  Signature of plan administrator  Date  Enter name of individual signing as plan administrator  Date  Enter name of individual signing as employer or plan sponsor  Freparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number	ELLI	S AND BADENHAUSEN O	RTHOPAEDIC	s, P.S.C			plan number (PN)	001
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) ELLIS, BADENHAUSEN ORTHOPAEDICS, P.S.C.  13151 MAGISTERIAL DRIVE, SUITE 200 LOUISVILLE  KY 40223 – 4103  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Index penalties of pertury and other penalties set forth in the instructions, i declare that I have examined this return/report, including accompanying schedules, statements and attachments, as we 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  Date  Enter name of individual signing as employer or plan sponsor  SIGN HERE Signature of DFE  Date  Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number  Preparer's telephone number  Preparer's telephone number  Preparer's telephone number	101(1	t, Indili blianing F	LIAIN			10		
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  ELLIS, BADENHAUSEN ORTHOPAEDICS, F.S.C.  13151 MAGISTERIAL DRIVE, SUITE 200  LOUISVILLE KY 40223-4103  Caution: A penalty for the late or incomplete filling of this return/ eport 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 accompanying schedules, statements and attachments, as we 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 blan administrator  Date Enter name of individual signing as plan administrator  SIGN HERE  Signature of DFE  Date  Enter name of individual signing as employer or plan sponsor  Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number					-	2b	Employer Identification N	Number (EIN)
LOUISVILLE KY 40223 – 4103  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Index penalties of peryry and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as we as the electronic version of this return/report, and to the best of my knowledge and belief, nil is true, correct, and complete.  SIGN HERE Signature of pijan admirhistrator  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 Signature of DFE  Date  Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number	City ELLI	or town, state or province, country, and ZIF  BADENHAUSEN ORTH	or foreign postal cod	e (if foreign, see ins	structions	Later Control	Plan Sponsor's telephon	e number
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 accompanying schedules, statements and attachments, as we 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 blan 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 Signature of DFE Date Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number						2d		uctions)
Signature of blan administrator  SIGN HERE Signature of employer/plan sponsor  Date Enter name of individual signing as plan administrator  SIGN HERE Signature of DFE Date Enter name of individual signing as employer or plan sponsor  SIGN HERE  Signature of DFE Date Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number	Jnder penal	ties of perjury and other penalties set forth in the in	structions. I declare that I	have examined this ret	turn/report i	unless reasona	able cause is established.	ments, as well
SIGN 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  SIGN Signature of DFE  Date Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number		X Mucklish Me)	x a	4-2016	TOU	N DILIG		
Signature of employer/plan sponsor   Date   Enter name of individual signing as employer or plan sponsor	S	ignature of plan administrator	Date	11	K. OOM EDDIS			
Signature of employer/plan sponsor  SIGN HERE Signature of DFE Date Date Enter name of individual signing as employer or plan sponsor  Enter name of individual signing as DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number  Or Paperwork Reduction Act Notice and OME Control Numbers and the individual signing as DFE								
Signature of DFE   Date   Enter name of individual signing as DFE	S	ignature of employer/plan sponsor	Date	Ent	er name	of individual sign	ing as employer or plan spo	onsor
Signature of DFE  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number								
Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's telephone number	S	gnature of DFE	Date	Ent	er name	of individual sign	ing as DFE	
or Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.	Preparer	's name (including firm name, if applica	able) and address (ii	n¢lude room or s	uite num	ber)	Preparer's telephone nui	mber
	or Paper	work Reduction Act Notice and OM	B Control Number	s, see the instru	ctions fo	or Form 5500.	For	m 5500 (2015

518401 12-07-15

Form 5500 (2015)		Page 2	
3a Plan administrator's name and address Same as Plan Sponsor ELLIS AND BADENHAUSEN ORTHOPAEDICS, P.S.C.		3b Administrator's 61-0678 3c Administrator's 502-587-12	573 s telephone number
13151 MAGISTERIAL DRIVE, SUITE 200 LOUISVILLE KY 40223-410	3		
4 If the name and/or EIN of the plan sponsor has changed since the la EIN and the plan number from the last return/report:	st return/report filed for this p	lan, enter the name,	4b EIN
a Sponsor's name			4c PN
Total number of participants at the beginning of the plan year			
6 Number of participants as of the end of the plan year unless otherwise	se stated (welfare plans comp	5	106
6a(1), 6a(2), 6b, 6c, and 6d).			
a (1) Total number of active participants at the beginning of the plan ye	ar	6a(1	V 00
- 1 Total number of active participants at the end of the plan year		0 10	02
riotilod of Separated participants receiving benefits		OL-	
or obparated participants entitled to infiltre handfire			1 21
The state of the s		0.1	
and the second of the second o	od to receive honofita	6-	106
· Total. Add lines 6d and 6e		Cf	106
complete this item)	an year (only defined contribut	tion plans	
The man to make to mindle of the fill of the than the	Par With accrued bonofite that	Construction Laboratory 10	95
100% vested		6h	,
complete this item)	n (only multiemployer plans	_	3
Ba If the plan provides pension benefits, enter the applicable pension fea 2E 2H 2J  If the plan provides welfare benefits, enter the applicable welfare feature.			
Plan funding arrangement (check all that apply)	9b Plan benefit arrangeme	ont (about all III II	
(1) Insurance	(1) Insurance	ent (check all that appl	у)
(2) Code section 412(e)(3) insurance contracts		n 412(e)(3) insurance co	ontracts
(3) X Trust	(3) X Trust	1412(e)(o) insurance co	ontracts
(4) General assets of the sponsor	(A) Consent sees	ets of the sponsor	
O Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)	are attached, and, where ind	icated, enter the numb	er attached.
a Pension Schedules	b General Schedules		
(1) R (Retirement Plan Information)	(1)	(Financial Information	<b>\</b>
(2) MB (Multiemployer Defined Benefit Plan and Certain Money	y (2) X	(Financial Information	
Purchase Plan Actuarial Information) - signed by the plan	(3) X _ 1 A	(Insurance Information	
actuary	(4) C	(Service Provider Info	
(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D	(DFE/Participating Pla	
Information) - signed by the plan actuary	(6) G		
	- G	(Financial Transaction	Schedules)