-	rm 5500-SF	Short Form Annu	al Return/Repoi Benefit Plan	rt of Small Employ	ee		OMB Nos. 1210-0110 1210-0089
	artment of the Treasury rnal Revenue Service	This form is required to be file		4065 of the Employee Retire	ement		2015
Employee B	epartment of Labor Benefits Security Administration			057(b) and 6058(a) of the Inte			orm is Open to ic Inspection
	enefit Guaranty Corporation			tructions to the Form 5500	-SF.		
For calend		Identification Information		and ending 12/31	/2015		
		X a single-employer plan		plan (not multiemployer) (Fi		king this bo	ox must attach a
A This re	turn/report is for:	a one-participant plan		mployer information in accor		-	
<b>B</b> This ret	urn/report is	the first return/report	the final return/report	t			
		an amended return/report		urn/report (less than 12 mont	hs)		
C Check	box if filing under:	X Form 5558	automatic extension		[] I	DFVC progr	am
		special extension (enter desc	ription)				
Part II	Basic Plan Info	prmation—enter all requested in	formation	1			
1a Name SOUTHERI	•	ALTH CARE FOR WOMEN, LLC	401(K) PROFIT SHARING		b Thre plan (PN)	number	001
				1	( )	tive date of	plan I/2012
		oyer, if for a single-employer plan) m, apt., suite no. and street, or P.0	D. Box)	2	<b>b</b> Emp (EIN)	oyer Identif	ication Number
		ce, country, and ZIP or foreign post ALTH CARE FOR WOMEN, LLC	tal code (if foreign, see ins	structions) 2	. ,	nsor's telepl	none number 22-5033
				2	<b>d</b> Busir		see instructions)
PAWTUCKE	DL STREET - SUITE 20 T, RI 02860	00				6211	11
3a Plan a	administrator's name a	nd address XSame as Plan Spon	sor.	3	<b>b</b> Admi	nistrator's E	IN
				3	<b>C</b> Admi	nistrator's t	elephone number
		e plan sponsor has changed since	the last return/report filed	for this plan, enter the	<b>b</b> EIN		
	e, EIN, and the plan hu sor's name	mber from the last return/report.		4	C PN		
5a Total	number of participants	at the beginning of the plan year.			5a		118
<b>b</b> Total	number of participants	at the end of the plan year			5b		117
		account balances as of the end of			5c		117
	,	rticipants at the beginning of the p		_	5d(1)		109
• •		articipants at the end of the plan ye	-		5d(2)		100
e Numl	ber of participants that	terminated employment during the	e plan year with accrued b	enefits that were less	5e		1
Under pen SB or Sche	alties of perjury and of	or incomplete filing of this retur ther penalties set forth in the instru nd signed by an enrolled actuary, a plate	ctions, I declare that I hav	e examined this return/report	t, includi	ng, if applic	
SIGN		/valid electronic signature.	09/26/2016	IAN HARING			
HERE	Signature of plan a	administrator	Date	Enter name of individual	signing	as plan adm	ninistrator
SIGN HERE							
	Signature of emplo	<b>oyer/plan sponsor</b> name, if applicable) and address (ii	Date	Enter name of individual		as employe telephone	
i ioparoi o							
For Paperw	ork Reduction Act Notio	ce and OMB Control Numbers, see th	e instructions for Form 550	0-SF.			Form 5500-SF (2015)

	Form 5500-SF 2015		Page <b>2</b>						
b	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility <b>If you answered "No" to either line 6a or line 6b, the plan cann</b> If the plan is a defined benefit plan, is it covered under the PBGC ir	an indeper and condit <b>tot use Fo</b>	ndent qualified public actions.) rm 5500-SF and must	instea	ant (IQ I <b>d use</b>	PA) Form	5500.		X Yes No   X Yes No   Not determined
Par	t III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Yea	ar			(b) End	of Year
а	Total plan assets	. 7a		4667					5378471
b	Total plan liabilities	7b			0				0
С	Net plan assets (subtract line 7b from line 7a)	. 7c		4667	860				5378471
8	Income, Expenses, and Transfers for this Plan Year		(a) Amou	nt				(b) T	otal
	Contributions received or receivable from: (1) Employers	8a(1)		526	976				
	(2) Participants	8a(2)		463	621				
	(3) Others (including rollovers)	8a(3)		22	914				
b	Other income (loss)	8b		-187	640				
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							825871
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		105	894				
е	Certain deemed and/or corrective distributions (see instructions)	8e			0				
f	Administrative service providers (salaries, fees, commissions)	8f		9	366				
g	Other expenses	. 8g			0				
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							115260
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i							710611
j	Transfers to (from) the plan (see instructions)	8j			0				
Par	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2K 2T 3B 3D	feature co	odes from the List of Pla	an Chai	racteri	stic Co	odes in t	he instruc	tions:
В	If the plan provides welfare benefits, enter the applicable welfare f	eature cod	les from the List of Plan	h Chara	acterist	tic Coc	les in th	e instruct	ons:
Part	V Compliance Questions								
10	During the plan year:				Yes	No	N/A		Amount
	Was there a failure to transmit to the plan any participant contribu	itions withi	n the time period						Amount
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)			10a		x			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		x			
С	Was the plan covered by a fidelity bond?			10c	Х				500000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		х			
e	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	her person he or all of	s by an insurance the benefits under	10e	х				23299

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	
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

Х

Х

Х

Х

10f

10g

10h

10i

10j

Has the plan failed to provide any benefit when due under the plan? .....

g Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....

If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR

2520.101-3.).....

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.....

Did the plan trust incur unrelated business taxable income? .....

f

h

i

j

Form 5500-SF 2015

Page **3** - 1

	(lf "`	es," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					
a		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see in: ting the waiver.		enter th Day	e date of	the letter ru Year	ling
lf	you c	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.		<b>.</b>		
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					
	of th	e PBGC?	-			Yes X	No
С		ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi 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	e of trust		14b	Trusťs E	IN	
14c	Narr	e of trustee or custodian		14d		's or custodi ne number	an's
Par	t IX	IRS Compliance Questions					
15a	Is th	e plan a 401(k) plan?		Ye	es	No	
15b		es," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals an hing contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?		b h	esign- ased safe ADP/ACI arbor test ethod		
15c	testir	ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "c ng method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.4 2)(ii))?		Y	es	No	
16a	Chec	k the box to indicate the method used by the plan to satisfy the coverage requirements under sect	ion 410(b):	Цр	atio 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	Ye	es	No	
17a	Hast	the plan been timely amended for all required tax law changes?		Ye	es	No	N/A
	for ta	the last plan amendment/restatement for the required tax law changes was adopted//////	•				tructions
17c		plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter placory 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	ın's last fa	avorable	
18		e Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2 e), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgir		Ye	S	No	
19	Were	in-service distributions made during the plan year?		Ye	es	No	
	lf "Y€	es," enter amount		19			
20	Were	e required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of wed), as required under section 401(a)(9)?		Ye	es	No	N/A

	Department of the Treasury Internal Revenue Service		Benefit Plan		-	2045		
	Department of Labor	Income Security Act of 197	iled under sections 104 and 4065 of the Employee 74 (ERISA), and sections 6057(b) and 6058(a) of tl	Retirement		2015		
-	ree Benefits Security Administration		Revenue Code (the Code)			Form is Open to lic Inspection		
Part			n accordance with the instructions to the Form	5500-SF.				
		t Identification Informatio fiscal plan year beginning	01/01/2015 and ending	10	101 1001			
		x a single-employer plan	a multiple-employer plan (not multiemploye		/ <u>31/201</u>			
A This	s return/report is for:	a one-participant plan	list of participating employer information in a foreign plan	accordance w	ith the form	n instructions)		
<b>B</b> This r	return/report is	the first return/report	the final return/report					
		an amended return/report	a short plan year return/report (less than 12	months)				
C Chec	ck box if filing under:	X Form 5558	automatic extension	Пг	)FVC progi	ram		
		special extension (enter des						
Part II	Basic Plan Infe	ormation—enter all requested i			-			
	ne of plan			1b Three	e-diait			
	ERN NEW ENGLANI ) PROFIT SHARII	) HEALTH CARE FOR WO	MEN, LLC		number	001		
( //	,			1c Effect	tive date of	plan		
2a Plan	n sponsor's name (emplo	oyer, if for a single-employer plan)		2b Emplo		ication Number		
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)					EIN) 45-2603721 ponsor's telephone number			
SOUTHERN NEW ENGLAND HEALTH CARE FOR WOMEN, LLC					1) 722-			
011 110	011111/ 110					see instructions)		
				Za Busine	ess coue (s	see instructions)		
333 SC	CHOOL STREET -	SUITE 200		20 Busine 6211		see instructions)		
AWTUC	CKET	SUITE 200 nd address <mark>X</mark> Same as Plan Spor	RI 02860	6211 <b>3b</b> Admin	L 1 1 nistrator's E			
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