

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2015</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015	
A This return/report is for:	☒ a single-employer plan ☐ a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions) ☐ a one-participant plan ☐ a foreign plan
B This 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 Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ DFVC program ☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information							
1a Name of plan SANTA MONICA FERTILITY CENTER, LLC 401(K) PROFIT SHARING PLAN	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">1b Three-digit plan number (PN) ►</td> <td style="width: 40%; text-align: center; padding: 2px;">001</td> </tr> <tr> <td colspan="2" style="padding: 2px;">1c Effective date of plan 10/01/2014</td> </tr> </table>	1b Three-digit plan number (PN) ►	001	1c Effective date of plan 10/01/2014			
1b Three-digit plan number (PN) ►	001						
1c Effective date of plan 10/01/2014							
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) SANTA MONICA FERTILITY CENTER, LLC 2825 SANTA MONICA BLVD., SUITE 100 SANTA MONICA, CA 90404	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">2b Employer Identification Number (EIN) 45-1876384</td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 2px;">2c Sponsor's telephone number 310-566-1470</td> <td></td> </tr> <tr> <td style="padding: 2px;">2d Business code (see instructions) 621111</td> <td></td> </tr> </table>	2b Employer Identification Number (EIN) 45-1876384		2c Sponsor's telephone number 310-566-1470		2d Business code (see instructions) 621111	
2b Employer Identification Number (EIN) 45-1876384							
2c Sponsor's telephone number 310-566-1470							
2d Business code (see instructions) 621111							
3a Plan administrator's name and address ☒ Same as Plan Sponsor.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">3b Administrator's EIN</td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 2px;">3c Administrator's telephone number</td> <td></td> </tr> </table>	3b Administrator's EIN		3c Administrator's telephone number			
3b Administrator's EIN							
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. a Sponsor's name	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">4b EIN</td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 2px;">4c PN</td> <td></td> </tr> </table>	4b EIN		4c PN			
4b EIN							
4c PN							
5a Total number of participants at the beginning of the plan year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5a</td> <td style="width: 40%; text-align: center; padding: 2px;">10</td> </tr> </table>	5a	10				
5a	10						
b Total number of participants at the end of the plan year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5b</td> <td style="width: 40%; text-align: center; padding: 2px;">11</td> </tr> </table>	5b	11				
5b	11						
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5c</td> <td style="width: 40%; text-align: center; padding: 2px;">11</td> </tr> </table>	5c	11				
5c	11						
d(1) Total number of active participants at the beginning of the plan year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5d(1)</td> <td style="width: 40%; text-align: center; padding: 2px;">10</td> </tr> </table>	5d(1)	10				
5d(1)	10						
d(2) Total number of active participants at the end of the plan year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5d(2)</td> <td style="width: 40%; text-align: center; padding: 2px;">11</td> </tr> </table>	5d(2)	11				
5d(2)	11						
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 2px;">5e</td> <td style="width: 40%; text-align: center; padding: 2px;">0</td> </tr> </table>	5e	0				
5e	0						

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	09/28/2016	JOHN KUMAR JAIN
	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

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets.....	7a	20671	142495
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	20671	142495
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	90372	
(2) Participants	8a(2)	32697	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	-1245	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		121824
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions)....	8e		
f Administrative service providers (salaries, fees, commissions).....	8f		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		
i Net income (loss) (subtract line 8h from line 8c)	8i		121824
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2A 2E 2F 2G 2J 2K 2T 3B 3D

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

Part V Compliance Questions

10 During the plan year:		Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a	☒	☐	☐	10226
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b	☐	☒	☐	
c Was the plan covered by a fidelity bond?.....	10c	☒	☐	☐	340000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d	☐	☒	☐	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.).....	10e	☐	☒	☐	
f Has the plan failed to provide any benefit when due under the plan?	10f	☐	☒	☐	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g	☐	☒	☐	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h	☐	☒	☐	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.....	10i	☐	☐	☐	
j Did the plan trust incur unrelated business taxable income?	10j	☐	☐	☒	

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below)..... ☐ Yes ☒ No

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

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?... ☐ Yes ☒ No

(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month Day Year

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year	12b	
c Enter the amount contributed by the employer to the plan for this plan year	12c	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?	☐ 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? ☐ Yes ☒ No

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

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

c If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

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

Part VIII Trust Information

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

Part IX IRS Compliance Questions

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

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

15c If the ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "current year testing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.401(m)-2(a)(2)(ii))? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

If "Yes," enter amount

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

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation**Short Form Annual Return/Report of Small Employee Benefit Plan**

This form is required to be filed under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089**2015****This Form is Open to Public Inspection****Part I Annual Report Identification Information**

For calendar plan year 2015 or fiscal plan year beginning		01/01/2015	and ending	12/31/2015
A This return/report is for:	☒ a single-employer plan	☐ a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)		
B This return/report is:	☐ a one-participant plan	☐ a foreign plan		
	☐ the first return/report	☐ the final return/report		
	☐ an amended return/report	☐ a short plan year return/report (less than 12 months)		
C Check box if filing under:	☒ Form 5558	☐ automatic extension		☐ DFVC program
	☐ special extension (enter description)			

Part II Basic Plan Information --- enter all requested information

1a Name of plan SANTA MONICA FERTILITY CENTER, LLC 401(K) PROFIT SHARING PLAN		1b Three-digit plan number (PN) ▶	001
		1c Effective date of plan	10/01/2014
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) SANTA MONICA FERTILITY CENTER, LLC 2825 SANTA MONICA BLVD., SUITE 100 US SANTA MONICA CA 90404		2b Employer Identification Number (EIN)	45-1876384
		2c Sponsor's telephone number (310) 566-1470	
		2d Business code (see instructions)	621111
3a Plan administrator's name and address ☒ Same as Plan Sponsor Name		3b Administrator's EIN	
		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.		4b EIN	
a Sponsor's name		4c PN	
5a Total number of participants at the beginning of the plan year		5a	10
b Total number of participants at the end of the plan year		5b	11
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)		5c	11
d(1) Total number of active participants at the beginning of the plan year		5d(1)	10
d(2) Total number of active participants at the end of the plan year		5d(2)	11
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested		5e	0

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE X	X 9/28/16	JOHN KUMAR JAIN
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE X	X 9/28/16	JOHN KUMAR JAIN
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

- 6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.
- c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	20,671	142,495
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	20,671	142,495
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	90,372	
(2) Participants	8a(2)	32,697	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	(1,245)	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		121,824
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		
i Net income (loss) (subtract line 8h from line 8c)	8i		121,824
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2A 2E 2F 2G 2J 2K 2T 3B 3D
- b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a	X		10,226
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		340,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			
j Did the plan trust incur unrelated business taxable income?	10j			X

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 current year from Schedule SB (Form 5500) line 40 11a
- 12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ... ☐ Yes ☒ No

(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month Day Year

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year	12b	
c Enter the amount contributed by the employer to the plan for this plan year	12c	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?		☐ 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?		☐ Yes ☒ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year		13a
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☐ Yes ☒ No
c If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)		
13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Part VIII Trust Information

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

Part IX IRS Compliance Questions

15a Is the plan a 401(k) plan:	☐ Yes ☐ No
15b If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?	☐ Design-based safe harbor method ☐ ADP/ACP test
15c If ADP/ACP test, did the 401(k) plan perform ADP/ACP testing for the plan year using the "current year testing method" for nonhighly compensated employees (Treas. Reg. section 1.401(k)-2(a)(2)(ii) and 1.401(m)-2(a)(2)(ii))?	☐ Yes ☐ No
16a Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b):	☐ Ratio Percentage Test ☐ Average Benefit Test
16b Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?	☐ Yes ☐ No
17a Has the Plan been timely amended for all required law changes?	☐ Yes ☐ No ☐ N/A
17b Date of the last plan amendment/restatement for the required tax law changes was adopted / / . Enter the applicable code . (See instructions for tax law changes and codes).	
17c If the plan sponsor is an adopter of a pre-approved master, prototype (M&P), or volume submitter plan that is subject to a favorable IRS opinion or advisory letter, enter the date of that favorable letter and the letter's serial number .	
17d If the plan is an individually-designed plan and received a favorable determination letter from IRS, please enter the date of plan's last favorable determination letter / / .	
18 Is the Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(l)(2) has been made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin Islands)?	☐ Yes ☐ No
19 Were in-service distributions made during the plan year?	☐ Yes ☐ No
If Yes, enter amount 	19
20 Were minimum required distributions made to 5% owners who have attained age 70 ½ (regardless of whether or not retired) as required under section 401(a)(9)?	☐ Yes ☐ No ☐ N/A

Application for Extension of Time To File Certain Employee Plan Returns

OMB No. 1545-0212

File With IRS Only

- ▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.
- ▶ Information about Form 5558 and its instructions is at www.irs.gov/form5558

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions) <u>SANTA MONICA FERTILITY CENTER, LLC</u> Number, street, and room or suite no. (if a P.O. box, see instructions) <u>2825 SANTA MONICA BLVD., SUITE 100</u> City or town, state, and ZIP code <u>SANTA MONICA</u> <u>CA</u> <u>90404</u>	B Filer's identifying number (see instructions) Employer identification number (EIN) (9 digits XX-XXXXXXX) <u>45-1876384</u> Social security number (SSN) (9 digits XXX-XX-XXXX)											
C	<table border="1"> <tr> <th data-bbox="937 434 1097 451" rowspan="2">Plan number</th><th colspan="3" data-bbox="1097 434 1458 451">Plan year ending--</th></tr> <tr> <th data-bbox="1097 451 1205 466">MM</th><th data-bbox="1205 451 1310 466">DD</th><th data-bbox="1310 451 1458 466">YYYY</th></tr> <tr> <td data-bbox="937 466 1097 483">0 0 1</td><td data-bbox="1097 466 1205 483">12</td><td data-bbox="1205 466 1310 483">31</td><td data-bbox="1310 466 1458 483">2015</td></tr> </table>	Plan number	Plan year ending--			MM	DD	YYYY	0 0 1	12	31	2015
Plan number	Plan year ending--											
	MM	DD	YYYY									
0 0 1	12	31	2015									
Plan name <u>SANTA MONICA FERTILITY CENTER, LLC 401(K) PROFIT SHARING PLAN</u>												

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

- 1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.
- 2 I request an extension of time until 10 / 17 / 2016 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until 10 / 17 / 2016 to file Form 8955-SSA (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 (see instructions)

- 4 I request an extension of time until _____ / _____ / _____ to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax ▶ a

b Enter the payment amount attached ▶ | b |

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date. ▶ c

5 State in detail why you need the extension:

[illegible]

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ►

Date ▶