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.

1210-0089

OMB Nos. 1210-0110

2015

This Form is Open to Public Inspection

| Part I Annual Report | t Identification Information | | | | | | | | | |
|---|--|--|----------------------------|------------------------------------|--------------------------|--|--|--|--|--|
| For calendar plan year 2015 or f | fiscal plan year beginning 01/01/2 | 2015 and ending 12 | 2/31/20 | 15 | | | | | | |
| 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 foreign plan | | | | | | | | | | |
| B This return/report is | the first return/report an amended return/report | the final return/report a short plan year return/report (less than 12 me | port (less than 12 months) | | | | | | | |
| C Check box if filing under: | X Form 5558 special extension (enter description) | automatic extension | | DFVC progr | am | | | | | |
| Part II Basic Plan Info | ormation—enter all requested in | formation | | | | | | | | |
| 1a Name of plan | CTIC MIDTOWN WEST, PC 401(K) | | ı | Three-digit plan number (PN) | 001 | | | | | |
| | | | 1c | Effective date of 01/01 | plan 1/2014 | | | | | |
| Mailing address (include roo | oyer, if for a single-employer plan) om, apt., suite no. and street, or P.C | , | | Employer Identif (EIN) 45-30 | ication Number 642428 | | | | | |
| BACK TO HEALTH CHIROPRAC | ce, country, and ZIP or foreign post TIC MIDTOWN WEST, PC | al code (ii foreigh, see instructions) | 2c 3 | Sponsor's telept 646-65 | none number 57-0032 | | | | | |
| 333 WEST 52ND ST NEW YORK, NY 10019 | | | 2d 1 | Business code (s | see instructions) | | | | | |
| 3a Plan administrator's name a | and address XSame as Plan Spons | sor. | 3b / | Administrator's E | EIN | | | | | |
| | | | 3c / | Administrator's t | elephone number | | | | | |
| name, EIN, and the plan nu | ne plan sponsor has changed since umber from the last return/report. | the last return/report filed for this plan, enter the | 4b | | | | | | | |
| a Sponsor's name | | | 4c | | | | | | | |
| 5a Total number of participants | s at the beginning of the plan year | | 5a | | 7 | | | | | |
| b Total number of participants | s at the end of the plan year | | 5b |) | 11 | | | | | |
| | | the plan year (defined benefit plans do not | 5с | | 11 | | | | | |
| d(1) Total number of active pa | articipants at the beginning of the pl | an year | 5d(′ | - | 7 | | | | | |
| d(2) Total number of active pa | articipants at the end of the plan yea | ar | 5d(2 | 2) | 10 | | | | | |
| than 100% vested | | | 5e | | 2 | | | | | |
| | | n/report will be assessed unless reasonable cau | | | | | | | | |
| Under penalties of perjury and o | other penalties set forth in the instruc | ctions, I declare that I have examined this return/rep | port, ind | cluding, if applica | able, a Schedule | | | | | |

belief, it is true, correct, and complete Filed with authorized/valid electronic signature SIGN 10/03/2016 JONATHAN COHEN **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

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

| Form 5500-SF 2015 | | Page 2 | | | | | | | | |
|--|-----------------------------|-------------------------|------------|----------|----------|------|--------|--------|------------|-------|
| 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 a under 29 CFR 2520.104-46? (See instructions on waiver eligibility a lf you answered "No" to either line 6a or line 6b, the plan cannot be a second to the plan cannot be a second | an indepen and condition | dent qualified public a | ccount | ant (IQ | PA) | | | > | Yes Yes | No No |
| C If the plan is a defined benefit plan, is it covered under the PBGC in | surance pr | ogram (see ERISA se | ection 4 | 021)? . | | Yes | No | No | t deterr | mined |
| Part III Financial Information | 1 | | | | | | | | | |
| 7 Plan Assets and Liabilities | | (a) Beginning | | | | | (b) En | d of Y | | |
| a Total plan assets | 7a | | 27 | 698 | | | | | 1476 | 04 |
| b Total plan liabilities | 7b | | 27 | 698 | + | | | | 1476 | 04 |
| Net plan assets (subtract line 7b from line 7a) Income, Expenses, and Transfers for this Plan Year | 7c | (a) Amou | | 090 | | | (b) | Total | | 04 |
| a Contributions received or receivable from: | | (a) Amot | unt | | | | (D) | Total | | |
| (1) Employers | 8a(1) | | 50 | 873 | | | | | | |
| (2) Participants | 8a(2) | | | 000 | | | | | | |
| (3) Others (including rollovers) | 8a(3) | | | 3209 | | | | | | |
| b Other income (loss) | 8b | | -6 | 912 | | | | | | |
| C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | | | | 1211 | 70 |
| Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | | | 0 | | | | | | |
| e Certain deemed and/or corrective distributions (see instructions) | 8e | | | 0 | | | | | | |
| f Administrative service providers (salaries, fees, commissions) | 8f | | 1 | 264 | | | | | | |
| g Other expenses | 8g | | | | | | | | | |
| h Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | | | | | 12 | 64 |
| i Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | | | | 1199 | 06 |
| j Transfers to (from) the plan (see instructions) | 8j | | | | | | | | | |
| Part IV Plan Characteristics | | | | | | | | | | |
| 9a If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 2T 3D B If the plan provides welfare benefits, enter the applicable welfare fermions. | | | | | | | | | | |
| Part V Compliance Questions | | | - Crian | 20101101 | | | | | | |
| 10 During the plan year: | | | | Yes | No | N/A | | Λn | ount | |
| Was there a failure to transmit to the plan any participant contributed described in 29 CFR 2510.3-102? (See instructions and DOL's V Program) | oluntary Fi | duciary Correction | 10a | | X | 1471 | | All | iount | |
| b Were there any nonexempt transactions with any party-in-interest reported on line 10a.) | ? (Do not ir | nclude transactions | 10a | | X | | | | | |
| C Was the plan covered by a fidelity bond? | | | 10c | Х | | | | | | 15000 |
| d Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty? | | | 10d | | X | | | | | |
| 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.) | ne or all of t | he benefits under | 10e | X | | | | | | 1235 |
| 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 a | | | | | X | | | | | |
| h If this is an individual account plan, was there a blackout period? (2520.101-3.) | (See instru | ctions and 29 CFR | 10g 10h | X | ^ | | | | | |
| i If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10 | he required | notice or one of the | 10ii | X | | | | | | |
| j Did the plan trust incur unrelated business taxable income? | | | 10i | | | X | | | | |
| Part VI Pension Funding Compliance | | | ıvj | | <u> </u> | | l | | | |
| 11 Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below) | | | | | | | | Г | Yes | ☐ No |
| 11a Enter the unpaid minimum required contribution for all years from | | | | | | 11a | | - | _ | |
| 12 Is this a defined contribution plan subject to the minimum funding | | | | | | | RISA? | | 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.) | | | | | | |
| а | If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see | | _ | | | ing | |
| If | granting the waiveryou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to lin | | Day _ | | Year | | |
| | Enter the minimum required contribution for this plan year | | 12b | | | | |
| | | | 12c | | | | |
| | Enter the amount contributed by the employer to the plan for this plan year | | 120 | | | | |
| | Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the negative 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? | | | 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 broof the PBGC? | | | | Yes X | No | |
| С | If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide which assets or liabilities were transferred. (See instructions.) | ntify the plan(s) to |) | | | | |
| | I3c(1) Name of plan(s): | 13c(2) | EIN(s) | | 13c(3) F | PN(s) | |
| | | | | | | | |
| Part | VIII Trust Information | | | | | | |
| | Name of trust K TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 401(K) PL | | | rust's EIN 3107768 | | | |
| | Name of trustee or custodian | | | | or custodia | an's | |
| DR. | JONATHAN COHEN | | telephone number 646-657-0032 | | | | |
| Day | LIV IDC Compliance Overtions | | | | 001-0002 | | |
| Par | t IX IRS Compliance Questions | | I — | | | | |
| 15a | Is the plan a 401(k) plan? | | ∐ Yes | 3 | No | | |
| 15b | If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)? | | De ba ha me | P/ACP | | | |
| 15c | If the ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the testing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 2(a)(2)(ii)? | | Yes | | | | |
| | Check the box to indicate the method used by the plan to satisfy the coverage requirements under se | | Ra pe | rcentage | | rage efit test | |
| 16b | Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by countries this plan with any other plans under the permissive aggregation rules? | | Yes | | | | |
| 17a | Has the plan been timely amended for all required tax law changes? | | Yes | 3 | No | N/A | |
| | Date the last plan amendment/restatement for the required tax law changes was adopted// for tax law changes and codes). | | | | _ (See ins | | |
| 17c | If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter advisory letter, enter the date of that favorable letter/ and the letter's serial | | ct to a fa | vorable IR | S opinion | or | |
| 17d | If the plan is an individually-designed plan and received a favorable determination letter from the IRS determination letter/ | , enter the date of | the plan | '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) made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virg | | Yes | | No | | |
| 19 | Were in-service distributions made during the plan year? | | Yes | 3 | No | | |
| | If "Yes," enter amount | | 19 | | | | |
| 20 | Were required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of retired), as required under section 401(a)(9)? | | Yes | 3 | No | N/A | |

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

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

2015

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

| | ort identification information | | - The major and major a | 0.404 |
|--|---|--|---|------------------------|
| For calendar plan year 2015 of | | 01/01/2015 and ending | 12/31/2 | |
| A = | X a single-employer plan | a multiple-employer plan (not multiemployer) list of participating employer information in a | | |
| A This return/report is for: | a one-participant plan | a foreign plan | ccordance with the | tomi instructions) |
| | | a loreigh plan | | |
| B This return/report is | X the first return/report | the final return/report | | |
| | an amended return/report | a short plan year return/report (less than 12 m | nonths) | |
| C 01-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1- | | | _ | |
| C Check box if filing under: | X Form 5558 | automatic extension | ☐ DEAG | orogram |
| | special extension (enter des | | | |
| | nformation—enter all requested | information | Tata = 0.00 | 77 |
| 1a Name of plan | ROPRACTIC MIDTOWN WES | T DC 401 (K) DIAN | 1b Three-digit plan number | er 001 |
| BACK TO REALITY CAT | ROPRACTIC MIDIOWN WES | or, FC 401(R) FLAN | (PN) | , 001 |
| | | | 1c Effective da | |
| | | | 01/01/2 | 014 |
| | pployer, if for a single-employer plan | | | lentification Number |
| | room, apt., suite no. and street, or P /ince, country, and ZIP or foreign po | stal code (if foreign, see instructions) | (EIN) 45- | |
| BACK TO HEALTH CH | HIROPRACTIC MIDTOWN WI | EST, PC | 2C Sponsors t | elephone number |
| | | | | ode (see instructions) |
| 333 WEST 52ND ST | | | 541990 | , |
| | | | | |
| NEW YORK | NY 1001: | | 3b Administrat | or's CIN |
| Sa Plan administrator's name | e and address Same as Plan Spo | nsor, | 3D Administrat | OI S EIIN |
| | | | 3c Administrat | or's telephone number |
| | | | | |
| | | | | |
| | | | | |
| | | e the last return/report filed for this plan, enter the | 4b EIN | |
| name, EIN, and the plan a Sponsor's name | number from the last return/report. | | 4c PN | |
| | -4 | | F- | 7 |
| | | r | El. | 11 |
| | | of the plan year (defined benefit plans do not | | |
| | | | . 5c | 11 |
| d(1) Total number of active | participants at the beginning of the | plan year | 5d(1) | 7 |
| d(2) Total number of active | participants at the end of the plan | /ear | . 5d(2) | 10 |
| | | he plan year with accrued benefits that were less | 5e | |
| | | ırn/report will be assessed unless reasonable ca | | - 2 1 |
| Under penalties of perjury and | other penalties set forth in the instr | ructions, I declare that I have examined this return/re | eport, including, if a | pplicable, a Schedule |
| SB or Schedule MB complete belief, it is true, correct, and c | d and signed by an enrolled actuary | , as well as the electronic version of this return/repo | rt, and to the best of | of my knowledge and |
| | INL (11) | JONATHAN COHE | ΞΝ | |
| SIGN HERE | 4 | 1 1/2/1/ | | n administrator |
| HERE Signature of pla | In attractive Control | Date (3) Enter name of individ | duai signing as piai | 1 auministrator |
| SIGN HERE | Industry | 101111 | | |
| Signature of em | plover/plan sponsor m/name, if applicable) and address | (include room or suite number) | dual signing as em Preparer's telept | ployer or plan sponsor |
| r reparer's name (including fin | miname, ii applicable) and address | (made room or saite namper) | l reparer s telepi | none number |
| | V | | | |
| | | | | |
| | | | | |

| | Form 5500-SF 2015 | | Page Z | | | | | |
|------|---|--------------|-------------------------|---------|----------|--------|------------|------------------------------|
| b | Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of a second | an indepen | dent qualified public a | ccount | ant (IQI | PA) | | |
| | under 29 CFR 2520.104-46? (See instructions on waiver eligibility a If you answered "No" to either line 6a or line 6b, the plan cann | | | | | | | 1100 1100 |
| | If the plan is a defined benefit plan, is it covered under the PBGC in | | | | | | | No Not determined |
| | t III Financial Information | <u>`</u> | | | | | | |
| | Plan Assets and Liabilities | | (a) Beginning | of Ye | ar | |) | (b) End of Year |
| | Total plan assets | 7a | (a) Dogmining | | 7,69 | 8 | | 147,604 |
| | Total plan liabilities | 7b | | | | | | |
| | Net plan assets (subtract line 7b from line 7a) | 7c | | 2 | 7,69 | 8 | | 147,604 |
| | Income, Expenses, and Transfers for this Plan Year | | (a) Amou | | | | | (b) Total |
| a | Contributions received or receivable from: (1) Employers | 8a(1) | *** | | 0,87 | 3 | | |
| | (2) Participants | 8a(2) | | 2 | 4,00 | 0 | 7 | THE PERSON NAMED IN COLUMN 1 |
| | (3) Others (including rollovers) | 8a(3) | | 5 | 3,20 | 9 | | |
| | Other income (loss) | 8b | | - | 6,91 | 2 | | |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | | 121,170 |
| | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | | | | 0 | | |
| | Certain deemed and/or corrective distributions (see instructions) | 8e | | | | 0 | de Har | KIE HILLY |
| _ | Administrative service providers (salaries, fees, commissions) | 8f | | | 1,26 | 4 | | |
| | Other expenses | 8g | | | | | | |
| | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | d . | | 1,264 |
| | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | | 119,906 |
| i | Transfers to (from) the plan (see instructions) | 8i | | | | | | |
| Par | t IV Plan Characteristics | | | | | | | |
| B | If the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits and the plan provides welfare for the plan provides welfare benefits and the plan provides welfare for the plan provides welfare benefits and the plan provides welfare for the plan provides welfare benefits and the plan provides welfare benefits and the plan provides welfare for the plan plan provides welfare benefits and the plan plan plan plan provides welfare benefits and the plan plan plan plan plan plan plan plan | eature cod | es from the List of Pla | n Chara | acterist | ic Cod | les in the | e instructions: |
| 10 | During the plan year: | | | | Yes | No | N/A | Amount |
| а | | /oluntary F | iduciary Correction | 10a | | х | - | |
| b | Were there any nonexempt transactions with any party-in-interest | | | 10b | | х | | |
| | reported on line 10a.) | | | | Х | | | 15.000 |
| C | Was the plan covered by a fidelity bond? | | | 10c | _ A | - | | 15,000 |
| | Did the plan have a loss, whether or not reimbursed by the plan's 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 the plan? (See instructions.) | ne or all of | the benefits under | 10e | х | | | 1,23 |
| f | Has the plan failed to provide any benefit when due under the pla | | | 10f | | Х | | |
| q | Did the plan have any participant loans? (If "Yes," enter amount a | s of year e | end.) | 10a | | Х | 77 | |
| | If this is an individual account plan, was there a blackout period? 2520.101-3.) | (See instru | ictions and 29 CFR | 10h | Х | | | |
| ī | If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10 | he required | d notice or one of the | 10i | х | | W. | |
| j | Did the plan trust incur unrelated business taxable income? | | | 10j | | | х | |
| Part | VI Pension Funding Compliance | | | | | | | |
| 11 | Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below). | | | | | | | |
| 11a | Enter the unpaid minimum required contribution for all years from | | | | | | | · |
| 12 | Is this a defined contribution plan subject to the minimum funding | | | | | | | RISA? Yes X No |

| | Form 5500-SF 2015 Page 3 - | | | | | |
|------------------|--|----------------|------------------|--------------------------|------------------------|-------------------|
| (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 instr nting the waiver | onth | nter the Day | | ne letter ruli Year | ng |
| If you | completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1 | 3. | | | | |
| b Ente | r the minimum required contribution for this plan year | | 12b | | | |
| C Ente | r the amount contributed by the employer to the plan for this plan year | | 12c | | | |
| | etract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the le lative amount) | | 12d | | | |
| e Wil | 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 | X No | |
| If " | es," enter the amount of any plan assets that reverted to the employer this year | | 13a | | | |
| | re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brough he PBGC? | | | | Yes X | No |
| | uring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify ch assets or liabilities were transferred. (See instructions.) | the plan(s) to | | | | |
| 13c(1 |) Name of plan(s): | 13c(2) | EIN(s) | | 13c(3) P | N(s) |
| | T | | | | | |
| Part VIII | Trust Information | | | | | |
| 14a Nam | e of trust | | 14b ⁻ | Frust's EIN | I | |
| BACK | TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 401(K) PL | | | 47-3 | 107768 | |
| 14c Nar | ne of trustee or custodian | | 14d | Trustee's telephone | or custodia | ın's |
| DR. | JONATHAN COHEN | | | | 657-003 | 32 |
| Part IX | IRS Compliance Questions | | | | | |
| 15a Is th | e plan a 401(k) plan? | | Ye | | No | |
| | es," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and ching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)? | | | | | PACP |
| testi | B ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "cuing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.40(2)(ii))? |)1(m)- | Ye | es | No | |
| 16a Che | ck the box to indicate the method used by the plan to satisfy the coverage requirements under sectio | n 410(b): | ∐ р | atio ercentage est | | rage efit test |
| | s the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by comb plan with any other plans under the permissive aggregation rules? | - | Ye | es | □No | |
| 17a Has | the plan been timely amended for all required tax law changes? | | Ye | es | No | □ N/A |
| for t | the last plan amendment/restatement for the required tax law changes was adopted ax law changes and codes). | | | | | |
| advi | e plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plat sory letter, enter the date of that favorable letter and prototype (M&P) and the letter's serial nu | ımber | | | | or |
| dete | e plan is an individually-designed plan and received a favorable determination letter from the IRS, en rmination letter | | | | orable/ | |
| | 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. Virgin | | Ye | | □ No | - |
| 19 Wer | e in-service distributions made during the plan year? | | Ye | es | No | |
| | es," enter amount | | 19 | | | |
| | e required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of whed), as required under section 401(a)(9)? | | Ye | es | No | □ N/A |

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

2015

This Form is Open to **Public Inspection**

| For calendar plan year 2015 of | | | | |
|--|---|---|---|--|
| . of saletimes promit from earle of | r fiscal plan year beginning | 01/01/2015 and ending | 12/31/20 | |
| | a single-employer plan | a multiple-employer plan (not multiemployer) | | |
| A This return/report is for: | a one-participant plan | list of participating employer information in a | ccordance with the fo | irm instructions) |
| | Date to see a | Пи 6 доцина д | | |
| 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 m | ionths) | |
| Check box if filing under: | X Form 5558 | automatic extension | ∏ DFVC pr | ogram |
| | special extension (enter desc | ziption) | ы, | |
| Part II Basic Plan In | formation—enter all requested in | <u> </u> | | |
| 1a Name of plan | Territoria de la constanta de | | 1b Three-digit | T |
| • | ROPRACTIC MIDTOWN WES | I, PC 401(K) PLAN | plan number | 001 |
| | | | 1c Effective date 01/01/20 | |
| Mailing address (include ro | ployer, if for a single-employer plan) pom, apt., suite no. and street, or P. | O. Box) | 2b Employer Ide (EIN) 45-3 | |
| | nce, country, and ZIP or foreign pos IROPRACTIC MIDTOWN WE | tal code (if foreign, see instructions) ST , PC | 2c Sponsor's tel 646-657- | • |
| 333 WEST 52ND ST | | | Total Control of the | e (see instructions) |
| NEW YORK | NY 10019 | | | |
| | and address XSame as Plan Spon | SOL | 3b Administrator | 's FIN |
| 4 If the name and/or EIN of | the plan sponsor has changed since | the last return/report filed for this plan, enter the | 4b EIN | |
| name, EIN, and the plan r a Sponsor's name | number from the last return/report. | | 4c PN | |
| - Control - Control | its at the heginning of the plan year | | - | |
| | | | | - |
| C Number of participants will | its at the clid of the plan year | | - | |
| complete this item) | | f the plan year (defined benefit plans do not | 5b | 13 |
| -111 | | f the plan year (defined benefit plans do not | 5b 5c | 1: |
| d(1) Total number of active p | participants at the beginning of the p | f the plan year (defined benefit plans do not | 5b 5c 5d(1) | 11 |
| d(1) Total number of active pd(2) Total number of activee Number of participants th | participants at the beginning of the participants at the end of the plan yearticipants at the end of the plan year terminated employment during the | f the plan year (defined benefit plans do not plan year | 5b 5c 5d(1) 5d(2) | 11 |
| d(1) Total number of active p d(2) Total number of active e Number of participants the than 100% vested | participants at the beginning of the p participants at the end of the plan ye at terminated employment during th | the plan year (defined benefit plans do not plan year | 5b 5c 5d(1) 5d(2) 5e | 11 |
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|--------------|--|---------------------------------------|---|----------|-------------|--------------------|---|-------------|------------|------------|---------|
| b | Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan cannuff the plan is a defined benefit plan, is it covered under the PBGC in | an indeper and condit ot use Fo | ndent qualified public a ions.) rm 5500-SF and must | ccount: | ant (IQ | PA) Form | • | ****** | X | Yes Yes | No No |
| | | isurance p | Lodiam (add ERIZA ae | cuan 4 | 021)7 | ᆜ | YAS [| TIMU | | neterm | iinen |
| Pa | rt III Financial Information | ř | | | | _ | | | _ | | |
| 7 | Plan Assets and Liabilities | | (a) Beginning | | | - | | (b) En | d of Ye | | |
| a | Total plan assets | 7a | | 2 | 7,69 | 8 | | | | 147 | 7,604 |
| | Total plan liabilities | 7b | | | | 1 | | | | _ | |
| c | Net plan assets (aubtract line 7b from line 7a) | 7c | | 2 | 7,69 | 8 | | | | 147 | 7,604 |
| 88 | Income, Expenses, and Transfers for this Plan Year | | (a) Amou | int | | | | (b) | Total | | |
| а | Contributions received or receivable from: | Ba(1) | | 5 | 0,87 | 3 | | | | | |
| - | (1) Employers | Ba(2) | | 2. | 4,00 | 0 | | | | | |
| | (2) Participants | Ba(3) | | | 3,20 | _ | | | | | |
| | (3) Others (including relievers) | 8b | | | 5,91 | _ | | | _ | - | |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | + | | | | 12. | 1,170 |
| | Benefits paid (including direct rollovers and insurance premiums | - 00 | | | | 1 | | | | | , , , , |
| | to provide benefits) | 8d | | | | 0 | | | | | |
| е | Certain deemed and/or corrective distributions (see instructions) | 8e | | | | 0 | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | | | 1,26 | 4 | | | | | |
| g | Other expenses | 8g | | | | _ | | | | | |
| _ <u>h</u> _ | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | \perp | | | | | 1,264 |
| _ <u>i</u> _ | Net income (loss) (subtract line 8h from line 8c) | . 8i | | | | _ | | | | 119 | 9,906 |
| j | Transfers to (from) the plan (see instructions) | 8j | | | | ┸ | | | | | |
| | t IV Plan Characteristics | | | | | | | | | | |
| 9a | If the plan provides pension benefits, enter the applicable pension | feature co | ides from the List of Pla | ал Сћа | racteri | stic Co | des in I | the inst | ructions | 3: | |
| В | 2E 2F 2G 2J 2K 2T 3D If the plan provides welfare benefits, enter the applicable welfare f | onture and | lac from the Liet of Plan | n Char | retoriel | ic Coc | os in th | o inetri | retions: | | _ |
| ь | If the plan provides werrare benefits, effer the applicable werrare of | cature cou | ies nom the cist of Figi | II CITAL | 30(01150 | .10 000 | C2 111 111 | ie iiisii t | 16((0)115. | | |
| Par | V Compliance Questions | | | | | | | | | | |
| 10 | During the plan year: | | | | Yes | No | N/A | | Am | ount | |
| a | Strate Postinistic and Strategic and Strateg | ıtlons wilhi | n the time period | | | | | | | | |
| | described in 29 CFR 2510.3-102? (See instructions and DOL's \ | | | 40 | Į. | х | | | | | |
| | Vivere (here any nonexempt transactions with any party-in-interes | | | 10a | - | _ | | | | | |
| U | reported on line 10a.) | | | 10b | | Х | | | | | |
| | Was the plan covered by a fidelity bond? | | | 10c | Х | | | | | | 15,00 |
| d | Did the plan have a loss, whether or not reimbursed by the plan's | fidelity bo | nd, that was caused | | | v | | | | | |
| | by fraud or dishonesty? | | | 10d | | Х | | | | | |
| е | Were any fees or commissions paid to any brokers, agents, or of | | | | | | | | | | |
| | carrier, insurance service, or other organization that provides son the plan? (See instructions.) | ne or all of | the benefits under | 10e | Х | | | | | | 1,23 |
| f | Has the plan failed to provide any benefit when due under the plan | | | 10f | | Х | | | | | |
| _ | | | | | - | X | | | | | |
| g | Did the plan have any participant loans? (If "Yes," enter amount a lift this is an individual account plan, was there a blackout period? | | Taracas and a second control of the | 10g | - | Λ. | | _ | | | |
| | 2520.101-3.) | , | | 10h | Х | | | | | | |
| i | If 10h was answered "Yes," check the box if you either provided to exceptions to providing the notice applied under 29 CFR 2520.10 | | | 10i | х | | | | | | |
| j | Did the plan trust incur unrelated business taxable income? | | | 10j | | | Х | | | | |
| Part | VI Pension Funding Compliance | | | | | | | | | | |
| 11 | Is this a defined benefit plan subject to minimum funding requiren 5500) and line 11a below). | | | | | | | | Г | Yes | ΠNα |
| 11a | Enter the unpaid minimum required contribution for all years from | | TO VENT TO | | | | | | | | |

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

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|---|--|------------------------------------|-----------------------|-------------------|
| (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 instructions, and er granting the waiver. Month | nter the Day | | e letter ruli 'ear | ng |
| If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13. | 461 | | | |
| 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 | 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 brought under the core of the PBGC? | | | Yes 🗓 t | 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) E | IN(s) | | 13c(3) P | N(s) |
| | | | | |
| Part VIII Trust Information | | | | |
| 14a Name of trust | 14b T | rust's EIN | | |
| BACK TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 401(K) PL | | 47-31 | 07768 | |
| 14c Name of trustee or custodian DR. JONATHAN COHEN | 14d Trustee's or custodian's telephone number 646-657-0032 | | | |
| Part IX IRS Compliance Questions | | | | |
| 15a Is the plan a 401(k) plan? | Ye | 5 | 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)? | ba ha | sign- sed safe rbor ethod | ADP test | /ACP |
| 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))? | Ye | 1 | No | |
| 16a Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b): | Re pe | rcentage | Ave ben | rage efit 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? | Ye | s | No | |
| 17a Has the plan been timely amended for all required tax law changes? | Ye: | S | No | □ N/A |
| 17b Date the last plan amendment/restatement for the required tax law changes was adopted Enter the a for tax law changes and codes). | pplicat | le code | (See ir | struction |
| 17c If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plan that is subject advisory letter, enter the date of that favorable letter and the letter's serial number | t to a fa | vorable IRS | 5 opinion | or |
| 17d If the plan is an individually-designed plan and received a favorable determination letter from the IRS, enter the date of the determination letter. | the plar | n's last favo | rable | |
| 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? | Ye | s | No | |
| If "Yes," enter amount | 19 | | | |
| Were required minimum distributions made to 5% owners who have altained age 70 ½ (regardless of whether or not retired), as required under section 401(a)(9)? | Ye | s | No | □ N/A |