## 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).

1210-0089

OMB Nos. 1210-0110

2015

This Form is Open to Public Inspection

▶ Complete all entries in accordance with the instructions to the Form 5500-SF. **Annual Report Identification Information** For calendar plan year 2015 or fiscal plan year beginning and ending x 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** This return/report is for: a one-participant plan a foreign plan the final return/report B This return/report is the first return/report an amended return/report a short plan year return/report (less than 12 months) **C** Check box if filing under: DFVC program Form 5558 automatic extension special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan 1b Three-digit plan number SEACOAST THORACIC & CARDIOVASCULAR SURGERY, INC. RETIREMENT 001 (PN) • 1c Effective date of plan 01/01/1997 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number Mailing address (include room, apt., suite no. and street, or P.O. Box) (EIN) 05-0492428 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c Sponsor's telephone number SEACOAST THORACIC & CARDIOVASCULAR SURGERY, INC. 401-331-4175 2d Business code (see instructions) ONE RANDALL SQUARE SUITE 414 621111 PROVIDENCE, RI 02904 **3a** Plan administrator's name and address | Same as Plan Sponsor. 3b Administrator's EIN 05-0492428 ONE RANDALL SQUARE SEACOAST THORACIC & CARDIOVASCULAR SURGERY, INC. 3c Administrator's telephone number PROVIDENCE, RI 02904 401-331-4175 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 number from the last return/report. 4c PN a Sponsor's name 5a 5a Total number of participants at the beginning of the plan year..... 5b **b** Total number of participants at the end of the plan year ..... Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c complete this item) 5d(1) d(1) Total number of active participants at the beginning of the plan year ...... 5d(2) d(2) Total number of active participants at the end of the plan year..... Number of participants that terminated employment during the plan year with accrued benefits that were less 5e than 100% vested..... Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

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

belief, it is t	rue, correct, and complete.							
SIGN HERE	Filed with authorized/valid electronic signature.	10/11/2016	ANTHONY MOULTON, M.D.					
	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 sp					
Preparer's	name (including firm name, if applicable) and address (include r	Preparer's telephone number						

Form 5500-SF 2015		Page <b>2</b>							
<ul> <li>Were all of the plan's assets during the plan year invested in elig</li> <li>Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility of you answered "No" to either line 6a or line 6b, the plan care</li> </ul>	of an indepen by and condition on on use For	dent qualified public a ons.) m 5500-SF and mus	ccount	ant (IQ ad use	PA)  Form	5500.		X Yes	No No
<b>c</b> If the plan is a defined benefit plan, is it covered under the PBGC	insurance pr	ogram (see ERISA se	ection 4	021)?		Yes	No	Not determ	ined
Part III Financial Information									
7 Plan Assets and Liabilities		(a) Beginning	of Ye	ar			(b) End		
a Total plan assets			102	2497				10070	7
<b>b</b> Total plan liabilities			400	107				40070	
C Net plan assets (subtract line 7b from line 7a)	7с			2497	-			10070	7
8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from:		(a) Amou	unt				(b) T	otal	
(1) Employers	8a(1)								
(2) Participants	8a(2)								
(3) Others (including rollovers)	8a(3)								
<b>b</b> Other income (loss)	8b		-1	790					
<b>C</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							-179	0
Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d								
Certain deemed and/or corrective distributions (see instructions).	<del>-    </del>								
f Administrative service providers (salaries, fees, commissions)									
g Other expenses	8g								
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h								0
i Net income (loss) (subtract line 8h from line 8c)	8i							-179	0
j Transfers to (from) the plan (see instructions)	···· 8j								
Part IV Plan Characteristics									
9a If the plan provides pension benefits, enter the applicable pension	on feature cod	des from the List of Pla	an Cha	racteris	stic Co	des in th	e instruc	tions:	
B If the plan provides welfare benefits, enter the applicable welfare	foature code	os from the List of Pla	n Char	actoriet	ic Coc	loc in the	inetructi	one:	
in the plant provides werrare benefits, effer the applicable werrare	e leature cout	es nom the List of Fia	ii Cilai	acterist	ic Coc	ies iii tiie	HISHUCH	oris.	
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 contril described in 29 CFR 2510.3-102? (See instructions and DOL's Program)	Voluntary Fi	duciary Correction	10a		X				
<b>b</b> Were there any nonexempt transactions with any party-in-interest					.,				
reported on line 10a.)			10b		X				
C Was the plan covered by a fidelity bond?			10c	X					20000
d Did the plan have a loss, whether or not reimbursed by the plan by fraud or dishonesty?			10d		X				
Were any fees or commissions paid to any brokers, agents, or carrier, insurance service, or other organization that provides so	other persons	by an insurance he benefits under			X				·
the plan? (See instructions.)			10e						
f Has the plan failed to provide any benefit when due under the p			10f		Х				
g Did the plan have any participant loans? (If "Yes," enter amount	•	,	10g		X				
h If this is an individual account plan, was there a blackout period 2520.101-3.)	•		10h		X				
i If 10h was answered "Yes," check the box if you either provided exceptions to providing the notice applied under 29 CFR 2520.1	the required	notice or one of the	10i						
j Did the plan trust incur unrelated business taxable income?			10j						
Part VI Pension Funding Compliance			,	1	<u> </u>	<u> </u>			
11 Is this a defined benefit plan subject to minimum funding require 5500) and line 11a below)								Yes	No
11a Enter the unpaid minimum required contribution for all years fro						11a		_	
12 Is this a defined contribution plan subject to the minimum funding						302 of EF	RISA?	Yes	X No

	F	orm 5500-SF 2015 Page <b>3</b> - 1								
	_ `	s," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)								
а		aiver of the minimum funding standard for a prior year is being amortized in this plan year, see inc ng the waiver		enter the Day	date of t	he letter rul Year	ing			
lf		mpleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line		Duy_		1 oui				
b	Enter t	ne minimum required contribution for this plan year		12b						
С	Enter th	ne amount contributed by the employer to the plan for this plan year		12c						
d		ct the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the		12d						
		ve amount)e minimum funding amount reported on line 12d be met by the funding deadline?		П	Yes	No 🗌	N/A			
Part		Plan Terminations and Transfers of Assets			100	110	1471			
		resolution to terminate the plan been adopted in any plan year?			Yes	s X No				
		s," 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 brough	ght under the co	ontrol		Yes X	No			
С	If duri	ng this plan year, any assets or liabilities were transferred from this plan to another plan(s), identiassets or liabilities were transferred. (See instructions.)								
•	13c(1) N	lame of plan(s):	13c(2)	EIN(s)		<b>13c(3)</b> PN(s)				
Part	: VIII	Trust Information								
14a	Name o	f trust		14b 1	Γrust's EIN	١				
14c	Name	of trustee or custodian		14d	Trustee's	or custodia	an's			
						telephone number				
Par	t IX	IRS Compliance Questions								
15a	Is the	plan a 401(k) plan?		Ye	S	No				
15b		"how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals an ng contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?		Design- based safe ADP/ACP harbor test method						
15c	testing	DP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "c method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.4(ii))?	101(m)-	Ye	S	No				
16a	Check	the box to indicate the method used by the plan to satisfy the coverage requirements under secti	on 410(b):		atio ercentage st	ge Average benefit test				
16b	<b>6b</b> 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?					No				
17a	Has the	e plan been timely amended for all required tax law changes?		Ye	S	No	N/A			
17b	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	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 p	lan is an individually-designed plan and received a favorable determination letter from the IRS, e ination letter/		the plai	n's last fav	vorable				
18		Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin		Yes	;	No				
19	Were in	n-service distributions made during the plan year?		Ye	s	No				
	If "Yes	" enter amount		19						
20		equired minimum distributions made to 5% owners who have attained age 70 $\frac{1}{2}$ (regardless of w ), as required under section 401(a)(9)?		Ye	s	No	N/A			

Form 5500-SF	OMB Nos, 1210							
Internal Revenue Service	Rollrement 2015 This Form is Open to Public Inspection							
Pepartment of Labor Employee Benefits Security Administration Pension Benefit Quaranty Corporation								
Part I Annual Report Id	► Complete all entries in dentification information	accordance with the ins	tructions to the Form 5	500-SF.				
For calendar plan year 2015 or fisc	al plan year beginning	01/01/2015	and ending	12/	31/2015			
A This return/report is for:	X a single-employer plan a one-participant plan	a multiple-employer list of participating e a foreign plan	plan (not multiemplayer) roployer information in a	(Filors check ccordance wit	ing this box must attach a h the form instructions)			
B This return/report is	the first return/report an amended return/report	the final return/report	irn/raport (less than 12 n	nonths)				
C Check box if filling under:	Form 5558 special extension (enter descr	automatic extension		DFVC program				
Part II Basic Plan Infor	mation—enter all requested in							
1a Name of plan SEACOAST THORACIC & C		2 1-19 (ERRET ERRETT	MENT	(PN)	umber 001			
					ve date of plan			
2a Plan sponsor's name (employe Malling address (include room, City or town, state or province.	er, if for a single-employer plan) , apt., sulte no, and street, or P.C , country, and ZtP or foreign post	). Sox) al code (if foreign, see ins	(ruellors)	2b Emplo (EIN)	yer Identification Number 05-0492428			
SEACOAST THORACIC &	2C Sponsor's telephone number							
ONE RANDALL SQUARE	401-331-4175  2d Business code (see instructions) 621111							
SUITE 414								
PROVIDENCE	RY 02904		P 8x					
3a Plan administrator's name and SEACOAST THORACIC & (	CARDIOVASCULAR SURGE	ERY, INC.		05-04	etrator's EIN 492428			
ONE RANDALL SQUARE SUITE 414					istrator's telephone number 331-4175			
PROVIDENCE	RI 02904							
4 if the name and/or EIN of the p name, EIN, and the plan numb a Sponsor's name	plan sponsor has changed since ber from the last return/report.	the last return/report filed	for this plan, enter the	4b EIN				
5a Total number of participants at	t the hegingles of the plan year		7"47 1 74.2 2 2000000000000000000000000000000000	4c PN 5a				
b Total number of participants of				5b				
C Number of participants with ac	count balances as of the end of t	the plan year (defined ber	refit plans do not	MIN. 3				
complete this item)	***************************************	######################################		5c				
d(1) Total number of active parti-				5d(1)				
<ul> <li>d(2) Total number of active parti</li> <li>Number of participants that te</li> </ul>								
than 100% vested		, , , , , , , , , , , , , , , , , , , ,		5e				
Caution: A penalty for the late or Under penalties of perjury and othe SB or Schedule MB completed and belief, it is take, correct, and combine	Incomplete filing of this return or penalties set forth in the instruc- Lalaned by an enrolled actuary, a	tiroport will be assessed	uniess reasonable ca e examined this return/re	nort including	if anniicable a Schedule			
SIGN. And	Moren	10/11/16	ANTHONY MOULT	ON, M.D.				
HERE Signatura of plantage	ministrator	Date ,.	Enter name of individ	ual signing as	s plan administrator			
SIGN link	Marin	Midic	ANTHONY MOULT					
HERE Signature of employe	oriplen sponsor	Date /	Enter name of individ	ual signing as	employer or plan sponsor			
Preparer's name (including firm nar	no, if applicable) and address (in	iclude room or suite numb	er)		slephone number			

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	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 if you answered "No" to either line 6a or line 6b, the plan cann	an indepe and cond not use Fo	endent qualified public : itlons.) orm 5500-SF and mus	accoun	tant (IC	PA) 	5500		_	_	No
c	If the plan is a defined benefit plan, is it covered under the PBGC in	isuranç <del>o</del>	program (see ERISA s	ection 4	1021)?	[	Yes	No	∏ No	t deten	mined
	rt III Financial Information					_			<del></del>		
	Plan Assets and Liabilities		(a) Boginnin	g of Yo	ar			(b) E	nd of Y	/oar	
a	Total plan assets	7 <u>a</u>		1	0245	7	-				.00707
	Total plan liabilities	7b	· Maria								
	Net plan assets (subtract line 7b from line 7a)	7c		1	0249	7				1	.00707
8	Income, Expenses, and Transfers for this Plan Year		(a) Amo	unt		$\perp$		<u>(b</u>	) Total		
	Contributions received or receivable from: (1) Employers	8a(1)									
	(2) Perticipants			***							
	(3) Others (including rollovers)	8a(3)	-111.	*****		┪	7711				
<u> </u>	Other Income (loss)	86			-179	0	T				
	Total Income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c									-1790
þ	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	88									
	Certain deemed and/or corrective distributions (see instructions)	8c				+					
f	Administrative service providers (salaries, fees, commissions)	81				-					
<u> </u>	Other expenses			****		+			<del></del>		
h	Total expenses (add lines 8d, 8e, 8f, and 8g)										0
ī	Net Income (loss) (subtract line 8h from line 8c)					┪					-1790
j	Transfers to (from) the plan (see instructions)										2,30
Pai	t IV Plan Characteristics		***								
9a	If the plan provides pension benefits, enter the applicable pension	feature co	ides from the List of Pl	an Cha	racteri:	stic Co	des in t	he inst	ruction	s:	
	2A 2E 3D If the plan provides welfare benefits, enter the applicable welfare for										
	in the plan provides werrare benefits, driter the applicable werrare to	anınıd ÇQ(	ges from the List of Pla	n Chara	ncterist	ic Cot	ios in th	e instru	ictions:	i	
Par	t V Compliance Questions								-		
10	During the plan year:				Yos	No	N/A		Δη	ount	
3		tions with	n the time period						7.01		. <u> </u>
	described in 29 CFR 2510.3-102? (See instructions and DQL's V Program)	'oluntary F	Iductory Correction	10a	] ,	х					
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	7 (Do not	include transactions	10b		х				<del></del>	
c				10¢	x						2000
d		fidelity bo	nd, that was caused	10¢		х					2000
e	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides some	er person	s by an insurance the benefits under								
f	the plan? (See instructions.)			100		x					
	Old the plan have any particle and leave 2 (if "Yes," and a service as of year and 3										
_ <del></del>		If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR				X					
	2520.101-3.)	****		10h		Х					
i	If 10h was answered "Yes," check the box if you either provided th exceptions to providing the notice applied under 29 CFR 2520.101	e regulred I-3	i natice or one of the	101							<u> </u>
j	Did the plan trust incur unrelated business taxable income?			10)							
Part											
11	is this a defined benefit plan subject to minimum funding requireme 6500) and line 11a below).							(Form	Tr	Yes	∏ No
11a	Enter the unpaid minimum required contribution for all years from 5	Schedulo	SB (Form 5500) line 4(	3	<u></u>		11a				
12	is this a defined contribution plan subject to the minimum funding	requireme	ents of section 412 of th	e Code	e or se	ction 3	02 of E	RISA?,		Yes	X No