

<b>Form 5500-SF</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b>  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).  <b>► Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <b>2015</b>  <b>This Form is Open to Public Inspection</b>
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<b>Part I Annual Report Identification Information</b>	
For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>	
<b>A</b> This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions) <input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan
<b>B</b> This return/report is	<input checked="" type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
<b>C</b> Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)

<b>Part II Basic Plan Information—enter all requested information</b>			
<b>1a</b> Name of plan <u>THE HEALTH INSTITUTE CASH BALANCE PLAN</u>	<b>1b</b> Three-digit plan number (PN) ►	<u>002</u>	
	<b>1c</b> Effective date of plan	<u>01/01/2015</u>	
<b>2a</b> 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) <u>JOHN G. SYMEONIDES, MD, LLC</u>  <u>P.O. BOX 354034</u> <u>PALM COAST, FL 32135</u>	<b>2b</b> Employer Identification Number (EIN) <u>01-0768756</u>		
	<b>2c</b> Sponsor's telephone number <u>386-864-9800</u>		
	<b>2d</b> Business code (see instructions)  <u>621111</u>		
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<b>3b</b> Administrator's EIN		
	<b>3c</b> Administrator's telephone number		
<b>4</b> 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. <b>a</b> Sponsor's name	<b>4b</b> EIN		
	<b>4c</b> PN		
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b>	<u>0</u>	
<b>b</b> Total number of participants at the end of the plan year .....	<b>5b</b>	<u>2</u>	
<b>c</b> Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) .....	<b>5c</b>		
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....	<b>5d(1)</b>	<u>2</u>	
<b>d(2)</b> Total number of active participants at the end of the plan year .....	<b>5d(2)</b>	<u>2</u>	
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>5e</b>	<u>0</u>	
<b>Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.</b> 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.	10/17/2016	JOHN G. SYMEONIDES, MD
	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
<b>a</b> Total plan assets.....	<b>7a</b>	0	250000
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	0	250000
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>	250000	
<b>(2)</b> Participants .....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>		
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		250000
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) ....	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions).....	<b>8f</b>		
<b>g</b> Other expenses .....	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g).....	<b>8h</b>		0
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		250000
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

**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:  
1A 1C 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
<b>a</b> 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) .....	<b>10a</b>		<input checked="" type="checkbox"/>		
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		<input checked="" type="checkbox"/>		
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>		<input checked="" type="checkbox"/>		
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		<input checked="" type="checkbox"/>		
<b>e</b> 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.) .....	<b>10e</b>		<input checked="" type="checkbox"/>		
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		<input checked="" type="checkbox"/>		
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....	<b>10g</b>		<input checked="" type="checkbox"/>		
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>				
<b>i</b> 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.....	<b>10i</b>				
<b>j</b> Did the plan trust incur unrelated business taxable income? .....	<b>10j</b>				

**Part VI Pension Funding Compliance**

<b>11</b> 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) .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>11a</b> Enter the unpaid minimum required contribution for all years from Schedule SB (Form 5500) line 40.....	<b>11a</b>
<b>12</b> Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ...	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.)
- | <b>13c(1)</b> Name of plan(s): | <b>13c(2)</b> EIN(s) | <b>13c(3)</b> PN(s) |
|--------------------------------|----------------------|---------------------|
|                                |                      |                     |

**Part VIII Trust Information**

- |   |  |
|---|--|
| <b>14a</b> Name of trust                | <b>14b</b> Trust's EIN                               |
| <b>14c</b> Name of trustee or custodian | <b>14d</b> 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 ..... **19**
- 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

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  ▶ <b>File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2015</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>THE HEALTH INSTITUTE CASH BALANCE PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶ <u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>JOHN G. SYMEONIDES, MD, LLC</u>	<b>D</b> Employer Identification Number (EIN) <u>01-0768756</u>
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

<b>Part I</b>	<b>Basic Information</b>																				
<b>1</b>	Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2015</u>																				
<b>2</b>	Assets: <table><tr><td><b>a</b> Market value .....</td><td><b>2a</b></td><td><u>0</u></td></tr><tr><td><b>b</b> Actuarial value .....</td><td><b>2b</b></td><td><u>0</u></td></tr></table>	<b>a</b> Market value .....	<b>2a</b>	<u>0</u>	<b>b</b> Actuarial value .....	<b>2b</b>	<u>0</u>														
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<b>b</b> Actuarial value .....	<b>2b</b>	<u>0</u>																			
<b>3</b>	Funding target/participant count breakdown <table><thead><tr><th></th><th>(1) Number of participants</th><th>(2) Vested Funding Target</th><th>(3) Total Funding Target</th></tr></thead><tbody><tr><td><b>a</b> For retired participants and beneficiaries receiving payment .....</td><td><u>0</u></td><td><u>0</u></td><td><u>0</u></td></tr><tr><td><b>b</b> For terminated vested participants .....</td><td><u>0</u></td><td><u>0</u></td><td><u>0</u></td></tr><tr><td><b>c</b> For active participants .....</td><td><u>2</u></td><td><u>0</u></td><td><u>0</u></td></tr><tr><td><b>d</b> Total .....</td><td><u>2</u></td><td><u>0</u></td><td><u>0</u></td></tr></tbody></table>		(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target	<b>a</b> For retired participants and beneficiaries receiving payment .....	<u>0</u>	<u>0</u>	<u>0</u>	<b>b</b> For terminated vested participants .....	<u>0</u>	<u>0</u>	<u>0</u>	<b>c</b> For active participants .....	<u>2</u>	<u>0</u>	<u>0</u>	<b>d</b> Total .....	<u>2</u>	<u>0</u>	<u>0</u>
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<b>c</b> For active participants .....	<u>2</u>	<u>0</u>	<u>0</u>																		
<b>d</b> Total .....	<u>2</u>	<u>0</u>	<u>0</u>																		
<b>4</b>	If the plan is in at-risk status, check the box and complete lines (a) and (b) ..... <input type="checkbox"/> <table><tr><td><b>a</b> Funding target disregarding prescribed at-risk assumptions .....</td><td><b>4a</b></td><td></td></tr><tr><td><b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....</td><td><b>4b</b></td><td></td></tr></table>	<b>a</b> Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....	<b>4b</b>															
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<b>5</b>	Effective interest rate .....	<b>5</b>	<u>6.45%</u>																		
<b>6</b>	Target normal cost .....	<b>6</b>	<u>196718</u>																		

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>		<u>07/29/2016</u>
	Signature of actuary	Date
<u>LORRAINE DORSA</u>	Type or print name of actuary	<u>14-04253</u>
		Most recent enrollment number
<u>AEGIS PENSION SERVICES, INC.</u>	Firm name	<u>904-686-1835</u>
		Telephone number (including area code)
<u>100 EXECUTIVE WAY</u> <u>SUITE 212</u> <u>PONTE VEDRA BEACH, FL 32082</u>	Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

**For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.**

**Schedule SB (Form 5500) 2015**  
**v. 150123**

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 4.72 %	2nd segment: 6.11 %	3rd segment: 6.81 %	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code) .....				<b>21b</b> 0
<b>22</b> Weighted average retirement age .....				<b>22</b> 62
<b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

**Part VI Miscellaneous Items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	<b>27</b>

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years .....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29) .....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6) .....	<b>31a</b>	196718	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	0	
<b>32</b> Amortization installments:	Outstanding Balance	Installment	
<b>a</b> Net shortfall amortization installment .....	0	0	
<b>b</b> Waiver amortization installment .....	0	0	
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>	0	
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) .....	<b>34</b>	196718	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement.....			0
<b>36</b> Additional cash requirement (line 34 minus line 35) .....	<b>36</b>	196718	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....	<b>37</b>	230718	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36) .....	<b>38a</b>	34000	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years.....	<b>40</b>	0	

**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)**

<b>41</b> If an election was made to use PRA 2010 funding relief for this plan:			
<b>a</b> Schedule elected .....	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
<b>b</b> Eligible plan year(s) for which the election in line 41a was made .....	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
<b>42</b> Amount of acceleration adjustment .....	<b>42</b>		
<b>43</b> Excess installment acceleration amount to be carried over to future plan years .....	<b>43</b>		

## Schedule SB, Part V - Statement of Actuarial Assumptions

### Target Assumptions:

Male Nonannuitant: 2015 Nonannuitant Male  
 Female Nonannuitant: 2015 Nonannuitant Female  
 Male Annuitant: 2015 Annuitant Male  
 Female Annuitant: 2015 Annuitant Female

Applicable months from valuation month: 0  
 Probability of lump sum: 99.00%  
 Use pre-retirement mortality: No

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Segment rates:	1.22	4.11	5.20
High Quality Bond rates:	N/A	N/A	N/A
Final rates:	4.72	6.11	6.81
Override:	0.00	0.00	0.00

### Salary Scale

Male: 0.00%  
 Female: 0.00%

### Withdrawal

Male: N/A  
 Female: N/A

### Withdrawal-Select

Male: N/A  
 Female: N/A

### Early Retirement Rates

Male: N/A  
 Female: N/A

### Subsidized Early Retirement Rates

Male: N/A  
 Female: N/A

### Options:

Use optional combined mortality table for small plans: Yes  
 Use discount rate transition: No  
 Lump sums use proposed regulations: Yes

### Actuarial Equivalent Floor

Stability period: plan year  
 Lookback months: 1  
 Nonannuitant: N/A  
 Annuitant: 2015 Applicable

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Current:	1.48	3.77	4.79
Override:	0.00	0.00	0.00

### Late Retirement Rates

Male: N/A  
 Female: N/A

### Marriage Probability

Male: 0.00%  
 Female: 0.00%  
 Expense loading: 0.00%

### Disability Rates

Male: N/A  
 Female: N/A

	<u>Mortality</u>	<u>Setback</u>
Male:	N/A	0
Female:	N/A	0

Name of Plan: The Health Institute Cash Balance Pla  
 Plan Sponsor's EIN: 01-0768756  
 Plan Number: 002

<b>Form 5500-SF</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b> 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). <b>► Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <b>2015</b>  <b>This Form is Open to Public Inspection</b>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>	

<b>A</b> This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)	
	<input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan	
<b>B</b> This return/report is	<input checked="" type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report	
	<input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)	
<b>C</b> Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program	
	<input type="checkbox"/> special extension (enter description)	

<b>Part II</b>	<b>Basic Plan Information—enter all requested information</b>
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<b>1a</b> Name of plan The Health Institute Cash Balance Plan	<b>1b</b> Three-digit plan number (PN) ► <u>002</u>
	<b>1c</b> Effective date of plan <u>01/01/2015</u>
<b>2a</b> 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) John G. Symeonides, MD, LLC  P.O. Box 354034  Palm Coast FL 32135	<b>2b</b> Employer Identification Number (EIN) <u>01-0768756</u> <b>2c</b> Sponsor's telephone number <u>386-864-9800</u> <b>2d</b> Business code (see instructions) <u>621111</u>
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number
<b>4</b> 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. <b>a</b> Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b> <u>0</u>
<b>b</b> Total number of participants at the end of the plan year .....	<b>5b</b> <u>2</u>
<b>c</b> Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) .....	<b>5c</b>
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....	<b>5d(1)</b> <u>2</u>
<b>d(2)</b> Total number of active participants at the end of the plan year .....	<b>5d(2)</b> <u>2</u>
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>5e</b> <u>0</u>

**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.

<b>SIGN HERE</b>	 Signature of plan administrator	Date	John G. Symeonides, MD Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	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
<b>a</b> Total plan assets	<b>7a</b>	0	250,000
<b>b</b> Total plan liabilities	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a)	<b>7c</b>	0	250,000
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers	<b>8a(1)</b>	250,000	
(2) Participants	<b>8a(2)</b>		
(3) Others (including rollovers)	<b>8a(3)</b>		
<b>b</b> Other income (loss)	<b>8b</b>		
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	<b>8c</b>		250,000
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits)	<b>8d</b>		
<b>e</b> Certain deemed and/or corrective distributions (see instructions)	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions)	<b>8f</b>		
<b>g</b> Other expenses	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g)	<b>8h</b>		0
<b>i</b> Net income (loss) (subtract line 8h from line 8c)	<b>8i</b>		250,000
<b>j</b> Transfers to (from) the plan (see instructions)	<b>8j</b>		

**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:  
1A 1C 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
<b>a</b> 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)		X		
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)		X		
<b>c</b> Was the plan covered by a fidelity bond?		X		
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
<b>e</b> 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.)		X		
<b>f</b> Has the plan failed to provide any benefit when due under the plan?		X		
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.)		X		
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				
<b>i</b> 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.				
<b>j</b> Did the plan trust incur unrelated business taxable income?				

**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.)		
<b>a</b> 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
<b>If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.</b>		
<b>b</b> Enter the minimum required contribution for this plan year .....	<b>12b</b>	
<b>c</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>12c</b>	
<b>d</b> 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) .....	<b>12d</b>	
<b>e</b> Will the minimum funding amount reported on line 12d be met by the funding deadline? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A

**Part VII Plan Terminations and Transfers of Assets**

<b>13a</b> Has a resolution to terminate the plan been adopted in any plan year? .....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If "Yes," enter the amount of any plan assets that reverted to the employer this year .....	<b>13a</b>	
<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>c</b> 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.)		
<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

**Part VIII Trust Information**

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

**Part IX IRS Compliance Questions**

<b>15a</b> Is the plan a 401(k) plan? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>15b</b> 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)? .....	<input type="checkbox"/> Design-based safe harbor method	<input type="checkbox"/> ADP/ACP test
<b>15c</b> 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)? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>16a</b> Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b): .....	<input type="checkbox"/> Ratio percentage test	<input type="checkbox"/> Average benefit test
<b>16b</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? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>17a</b> Has the plan been timely amended for all required tax law changes? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
<b>17b</b> 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).		
<b>17c</b> 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 .. .		
<b>17d</b> 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 .. .		
<b>18</b> 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)? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>19</b> Were in-service distributions made during the plan year? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes," enter amount .....	<b>19</b>	
<b>20</b> 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)? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2015</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>	
► <b>Round off amounts to nearest dollar.</b>	
► <b>Caution:</b> A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.	
<b>A</b> Name of plan The Health Institute Cash Balance Plan	<b>B</b> Three-digit plan number (PN) <span style="float: right;">►</span> <u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF The Health Institute	<b>D</b> Employer Identification Number (EIN) <u>01-0768756</u>
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

<b>Part I Basic Information</b>			
1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2015</u>			
2 Assets:			
a Market value .....	<b>2a</b>	0	
b Actuarial value .....	<b>2b</b>	0	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment .....	0	0	0
b For terminated vested participants .....	0	0	0
c For active participants .....	2	0	0
d Total .....	2	0	0
4 If the plan is in at-risk status, check the box and complete lines (a) and (b) <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....	<b>4b</b>		
5 Effective interest rate .....	<b>5</b>	6.45%	
6 Target normal cost .....	<b>6</b>	196,718	

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	<div style="text-align: center;">           Signature of actuary       </div> <div style="text-align: center;">         Lorraine Dorsa          Type or print name of actuary          Aegis Pension Services, Inc.          Firm name          100 Executive Way          Suite 212          Ponte Vedra Beach FL 32082          Address of the firm       </div>	<div style="text-align: center;"> <div style="text-align: right;">           Date          1404253       </div>         Most recent enrollment number          904-686-1835          Telephone number (including area code)       </div>
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Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year).....	0	0
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....	0	0
9	Amount remaining (line 7 minus line 8) .....	0	0
10	Interest on line 9 using prior year's actual return of <u>0.00</u> % .....	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year).....		0
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>0.00</u> % .....		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return .....		0
c	Total available at beginning of current plan year to add to prefunding balance .....		0
d	Portion of (c) to be added to prefunding balance.....		0
12	Other reductions in balances due to elections or deemed elections .....	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12) .....	0	0

Part III Funding Percentages			
14	Funding target attainment percentage .....	14	100.00 %
15	Adjusted funding target attainment percentage .....	15	100.00 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	0.00 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage. ....	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/14/2016	250,000	0			
Totals ▶			18(b)	250,000	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:	
a Contributions allocated toward unpaid minimum required contributions from prior years.....	19a 0
b Contributions made to avoid restrictions adjusted to valuation date .....	19b 0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....	19c 230,718
20 Quarterly contributions and liquidity shortfalls:	
a Did the plan have a "funding shortfall" for the prior year? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c If line 20a is "Yes," see instructions and complete the following table as applicable:	
Liquidity shortfall as of end of quarter of this plan year	
(1) 1st	(2) 2nd
(3) 3rd	(4) 4th

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 4.72%	2nd segment: 6.11%	3rd segment: 6.81%	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code) .....				<b>21b</b> 0
<b>22</b> Weighted average retirement age .....				<b>22</b> 62
<b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

**Part VI Miscellaneous Items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment. ....	<b>27</b>

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years .....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) .....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29) .....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6) .....	<b>31a</b>	196,718	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	0	
<b>32</b> Amortization installments:	Outstanding Balance	Installment	
<b>a</b> Net shortfall amortization installment .....	0	0	
<b>b</b> Waiver amortization installment .....	0	0	
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>	0	
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) .....	<b>34</b>	196,718	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement .....			
<b>36</b> Additional cash requirement (line 34 minus line 35) .....	<b>36</b>	196,718	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....	<b>37</b>	230,718	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36) .....	<b>38a</b>	34,000	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years .....	<b>40</b>	0	

**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)**

<b>41</b> If an election was made to use PRA 2010 funding relief for this plan:			
<b>a</b> Schedule elected .....	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
<b>b</b> Eligible plan year(s) for which the election in line 41a was made .....	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
<b>42</b> Amount of acceleration adjustment .....	<b>42</b>		
<b>43</b> Excess installment acceleration amount to be carried over to future plan years .....	<b>43</b>		

## Schedule SB, line 19 - Discounted Employer Contributions

Interest Rates for Contribution Year End Date: 12/31/2015

Effective: 6.45%

Late Quarterly: 11.45%

<u>Effective Date</u>	<u>Amount</u>	<u>Discounted</u>
04/14/2016	\$250,000	\$230,718
	<hr/> \$250,000	<hr/> \$230,718

**Name of Plan:** The Health Institute Cash Balance Pla  
**Plan Sponsor's EIN:** 01-0768756  
**Plan Number:** 002  
**Plan Sponsor's Name:** The Health Institute

Plan Name: The Health Institute Cash Balance Plan  
 EIN: 01-0768756  
 PIN: 002  
 Plan Year End: 12/31/2015

<b>NRA</b>	<b>Active Group Weight =(TNC+FT)xNRA</b>	<b>Weighted Average Retirement Age</b>
<b>62</b>	<b>12,196,516</b>	
Total:	12,196,516	<b>62</b>

## Schedule SB, Part V - Summary of Plan Provisions

### Eligibility Requirements

Age (yrs) : 21  
 Age (months) : 0  
 Wait (months) : 12  
 Two year eligibility : No

### Service/Participation Requirements

Definition of years: Hours worked  
 Continuing hours: 1,000  
 Excluded classes: Union Members  
 Non-resident alien  
 Other

### Earnings

Total compensation excluding : Other

<u>Retirement</u>	<u>Normal</u>	<u>Early</u>	<u>Subsidized Early</u>	<u>Disability</u>	<u>Death</u>
Age:	62				
Service:	0				
Participation:	5				
Defined:	1st of month following				

### Benefit Reduction / Mortality table & setback

<b>Male:</b>	Actuarial Equivalence	Actuarial Equivalence	N/A	0
<b>Female:</b>	Actuarial Equivalence	Actuarial Equivalence	N/A	0

<b>Rates - Male:</b>	N/A	N/A	N/A
<b>Rates - Female:</b>	N/A	N/A	N/A

<b>Use Social Security Retirement Age:</b>	No	<b>REACT Benefits Percentage:</b>	50.00%
<b>Vesting Schedule:</b>	3 Cliff	<b>Pre-retirement death benefit</b>	
<b>Vesting Definition:</b>	Hours Worked	<b>Percentage of accrued benefit:</b>	100.00%
		<b>Death Benefit Payment method:</b>	PVAB

	<u>Annuity</u>	<u>Percent</u>	<u>Years</u>
<b>Normal:</b>	Life only	0.00%	0
<b>QJSA:</b>	Joint and contingent	50.00%	0

### Significant Changes in Plan Provisions Since Last Valuation

**Name of Plan:** The Health Institute Cash Balance Plan  
**Plan Sponsor's EIN:** 01-0768756  
**Plan Number:** 002