## Form 5500-SF

Department of the Treasury

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

**Benefit Plan** Internal Revenue Service Department of Labor

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).

Short Form Annual Return/Report of Small Employee

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

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

3b Administrator's EIN  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  3 Sponsor's name  4b EIN  4c PN  5a Total number of participants at the beginning of the plan year	Part I		t Identification Information										
A This return/report is for:    a one-participant plan   a toreign plan   a toreign plan   a toreign plan   a toreign plan     B This return/report	For calend	ar plan year 2016 or	fiscal plan year beginning 01/01/2	2016 	and ending 1	2/31/2016							
B This return/report is	a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a												
B This return/report is	A This return/report is for:			_ ' ' "	mployer information in a	accordance with the form instructions.)							
C Check box if filing under:			a one-participant plan	a foreign plan									
C Check box if filing under:	<b>D</b> —		Duba Cast action from all	Duba Caal as town town and									
C Check box if filing under:	<b>B</b> This ret	urn/report is	- H										
Part II Basic Plan Information—enter all requested information  1			an amended return/report	a short plan year retu	rn/report (less than 12 m	nonths)							
Part II Basic Plan Information—enter all requested information  1	C Check	box if filing under:	☐ Form 5558	automatic extension		□ DEVC program							
Part II   Basic Plan Information—enter all requested information   1a Name of plan   WINDSOR MEDICAL, PC 401(K) PLAN   Dot     2a Plan sponsor's name (employer, if for a single-employer plan)     Mailing address (include room, apr., suite no, and street, or P.O. Box)     WINDSOR MEDICAL, PC 401(K) PLAN     2b Employer Identification Number (EIN) 45-4565038     2c Sponsor's telephone number (EIN) 45-4565038     2c Sponsor's telephone number (BIN) 45-4565038     2c Sponsor's telephone number (BIN) 45-4565038     2d Business code (see instructions)     3a Plan administrator's name and address   Same as Plan Sponsor.     4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.     3 Sponsor's name     4 C PN     5a Total number of participants at the beginning of the plan year     5b Total number of participants at the end of the plan year     5c Number of participants at the end of the plan year     6d(1) Total number of active participants at the beginning of the plan year     6d(2) Total number of active participants at the end of the plan year     6d(2) Total number of active participants at the end of the plan year     6d(2) Total number of active participants at the end of the plan year     6d(3) Total number of active participants at the end of the plan year     6d(3) Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested     6d(3) Total number of active participants at the end of the plan year     6d(4) Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested     6d(3) Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested     6d(4) Total number of participants at the end of the plan year     6d(4) Total number of participants at the end of the plan year     6d(4) T		-	H	<b>—</b>		Di vo program							
The Name of plan   The Plan   T	Dort II	Pagia Dian Inf											
Pain sponsor's name (employer, if for a single-employer plan)   C   Effective date of plan			Officiation—enter all requested in	itormation		1b Thron digit	<u> </u>						
CPN   O11   1c   Effective date of plan   01101/2002   2d   Employer (leftication Number (EIN) 45-4555038   CEV) or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)   2d   Employer (leftication Number (EIN) 45-4555038   CEV)   45-4555038			PLAN				r						
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) WNDSOR MEDICAL, PC  2b Employer Identification Number (EIN) 49-4868038  2c Sponsor's telephone number 831-393-87000  2d Business code (see instructions) 821111  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name  5a Total number of participants at the beginning of the plan year. c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)  d(1) Total number of active participants at the end of the plan year. c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)  d(2) Total number of active participants at the end of the plan year. e Number of participants that terminated employment during the plan year with accrued benefits that were less 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 perityr give the plan of the plan year with accrued benefits that were less than 100% vested of participants and the remainated employment during the plan year with accrued benefits that were less than 100% vested of participants and the remainated employment during the plan year with accrued benefits that were less for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Under penalties of perityr and other penalties set forth in the instructions, 1 declare that 1 have examined this return/report, and to the bes		,											
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City of town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  2c Sponsor's telephone number 631-393-6700  2d Business code (see instructions)  5utre 5131  MELVILLE, NY 11747  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's telephone number 3c Administrator's telephone number 6c Administrator's telephone number			, , , , , , , ,			' '							
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C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	_												
d(1) Total number of active participants at the beginning of the plan year			• •			50	8						
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d(2) Total number of active participants at the end of the plan year						5d(1)	2						
Provided the second street of participants that terminated employment during the plan year with accrued benefits that were less 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.    SIGN   Filed with authorized/valid electronic signature.   O6/09/2017   SCOTT SPRINGER, D.O.													
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.  Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  SIGN HERE  Filed with authorized/valid electronic signature.  O6/09/2017  SCOTT SPRINGER, D.O.  Enter name of individual signing as plan administrator  Signature of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor						50(2)	3						
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SIGN   HERE   Filed with authorized/valid electronic signature.   06/09/2017   SCOTT SPRINGER, D.O.				as well as the electronic ve	ersion of this return/repo	rt, and to the best o	f my knowledge and						
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				06/09/2017	SCOTT SPRINGER I	0.0							
Signature of plan administrator  SIGN HERE  Signature of employer/plan sponsor  Date  Enter name of individual signing as plan administrator  Enter name of individual signing as employer or plan sponsor	HERE												
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor		Signature of plan	administrator	Date	Date Enter name of indi		administrator						
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	HERE	Signature of empl			1	مراما منامات مم مسلم							
						auai signing as emp	loyer or plan sponsor						
	Preparer's												
	Preparer's						•						
	Preparer's						•						
	Preparer's						•						

Form 5500-SF 2016 Page **2** 

6a	Were all of the plan's assets during the plan year invested in eligib	le assets?	(See instructions.)						X Ye	es No	
	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	and condit	tions.)						X Ye	es 🗌 No	
	If the plan is a defined benefit plan, is it covered under the PBGC in						-	No	Not de	termined	
Par	t III Financial Information						_				
7	Plan Assets and Liabilities		(a) Beginning	of Year				(b) End	of Year		
а	Total plan assets	7a		272908					2124	)9	
b	Total plan liabilities	7b		C	)					0	
С	Net plan assets (subtract line 7b from line 7a)	7c		272908	3				2124	)9	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amour	nt				(b) 1	Γotal		
	Contributions received or receivable from:	- 413		C							
	(1) Employers	8a(1)		0							
	(2) Participants	8a(2)		C							
	(3) Others (including rollovers)	8a(3)		18406							
	Other income (loss)	8b		10400					1840	<u> </u>	
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							1040	<i></i>	
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		78423	3						
	Certain deemed and/or corrective distributions (see instructions).	8e		C	)						
f	Administrative service providers (salaries, fees, commissions)	8f		482	2						
g	Other expenses	8g		0							
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					78905				
i	Net income (loss) (subtract line 8h from line 8c)	8i							-6049	99	
j	Transfers to (from) the plan (see instructions)	8j	0								
Par	t IV Plan Characteristics	,	l.								
9a	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 3D	feature co	odes from the List of Pl	an Cha	racteri	stic Co	odes in	the ins	tructions:		
b	If the plan provides welfare benefits, enter the applicable welfare f	eature cod	les from the List of Pla	n Chara	acteris	tic Cod	des in t	he instr	uctions:		
Part	t V Compliance Questions										
10	During the plan year:				Yes	No	N/A		Amoun	t	
а	Was there a failure to transmit to the plan any participant contributed described in 29 CFR 2510.3-102? (See instructions and DOL's Verogram)	oluntary F	Fiduciary Correction	10a		X					
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		X					
С	Was the plan covered by a fidelity bond?			10c	X					50000	
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		X					
е	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.)									1338	
f	f Has the plan failed to provide any benefit when due under the plan?					X					
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	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 to exceptions to providing the notice applied under 29 CFR 2520.10			10i							

Form	5500	-SF	201	6

Page 3-	1
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Part	VI	Pension Funding Compliance							
11		s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and c n 5500) and line 11a below)				[] `	∕es X No		
		the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40			11a				
12		s a defined contribution plan subject to the minimum funding requirements of section 412 of the Co A?				<b>│</b>	res X No		
	(lf "\	es," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
	grant	aiver of the minimum funding standard for a prior year is being amortized in this plan year, see ins ing the waiver	/lonth _	s, and	d enter t Day		of the lette Year _	er ruling	
If	you co	empleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1	13.	1		1			
b	Enter	the minimum required contribution for this plan year			12b				
С	Enter	the amount contributed by the employer to the plan for this plan year			12c				
d		act the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the live amount)			12d				
		ne 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	s X N	lo	
	If "Y€	s," enter the amount of any plan assets that reverted to the employer this year			13a				
b		e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brougol of the PBGC?		er the			Yes	No	
С		ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identinassets or liabilities were transferred. (See instructions.)	ify the p	olan(s)	) to				
	13c(1)	Name of plan(s):	1	3c(2)	EIN(s)		<b>13c(3)</b> PN(s)		
Part	VIII	Trust Information							
14a	Name	of trust			14b <sup>-</sup>	Trust's E	EIN		
14c	Name	of trustee or custodian			<b>14d</b> Trustee's or custodian's telephone number				
Par	t IX	IRS Compliance Questions							
15a	Is the	plan a 401(k) plan? If "No," skip b		Yes			No		
		lid the plan satisfy the nondiscrimination requirements for employee deferrals under section (3) for the plan year? Check all that apply:	IШ		n-based narbor	d [	Prior ye test	ear" ADP	
				"Curre	ent year test	<u>"</u>	N/A		
16a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:					O Average Average N/A benefit test N/A				
	<b>16b</b> Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?						No		
	the le								
	letter	plan is an individually-designed plan that received a favorable determination letter from the IRS, er	nter the	date	of the m	nost rece	ent determi	nation	
18	Were	ed Benefit Plan or Money Purchase Pension Plan Only: any distributions made during the plan year to an employee who attained age 62 and had not sepa e?		rom	Ye	s [	No		
19	Was a	any plan participant a 5% owner who had attained at least age 70 $^{1\!\!/}$ during the prior plan year?			Ye	s	No		

## 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 section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

4 and 4065 of the Employee d section 6057(b) and 6058(a) of

This Form is Open to Public

OMB Nos. 1210-0110

1210-0089

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

Annual Penor	t Identification Information	1		10 /24 /201	
or calendar plan year 2016 or t	fiscal plan year beginning	01/01/2010	and ending	12/31/201	
THE STATE OF THE S	x a single-employer plan	a multiple-employer plan a list of participating emp	(not multiemployer) loyer information in	(Filers checking the accordance with the	nis box must attach ne form instructions.)
This return/report is for:	a one-participant plan	a foreign plan			
to the second control of	the first return/report	the final return/report			
This return/report is:	an amended return/report	a short plan year return/	report (less than 12		
Check box if filing under:	Form 5558	automatic extension		DFVC	program
	special extension (enter des	cription)			
Basic Plan In	formation enter all requeste	d information		1b Three-dig	nit line
a Name of plan				plan num	ber
Windsor Medical, P	C 401(k) Plan			(PN) ▶	001
				1c Effective 91/91/	2002
2a Plan sponsor's name (em	ployer, if for a single-employer plan room, apt., suite no. and street, or r	) P.O. Box)			r Identification Number
City or town, state or prov Windsor Medical, P	rince, country, and ZIP of loteigh po	ostal code (if foreign, see instru	ctions)	2c Sponsor (631)	's telephone number 393-6700
				No de la companya de	s code (see instructions)
105 Maxess Road					
Suite S131 US Melville NY 11747 _		<u> </u>		3b Adminis	tratorie EIN
3a Plan administrator's nam	e and address X Same as Plan	Sponsor		30 Adminis	liator 5 Eliv
				3c Adminis	strator's telephone number
4 If the name and/or EIN o	of the plan sponsor has changed sin	ice the last return/report filed fo	r this plan, enter the	4b EIN	
name, EIN, and the plan	number from the last return/report.			4c PN	
a Sponsor's name	ants at the beginning of the plan ye	ar	*************************	5a	9
	the and of the plan year		*********	5b	
The second secon	with account bolonces as of the end	of the clan year (only delined	CONTRIBUTION PICTO	5c	8
I-A- Abin (tom)		44010588805986988688448884488		5d(1)	3
d(1) Total number of active	e participants at the beginning of the	e plan year		E-1(0)	3
Number of participants	e participants at the end of the plan that terminated employment during	the plan year with accrued ben	efits that were	5e	0
VACTOR				cause is establi	shed.
Caution: A penalty for the	late or incomplete filing of this r	eturn/report will be assessed	Uniess reasonable	rn/report_including	if applicable, a Schedule
Under penalties of perjury a	and other penalties set forth in the in ted and signed by an enrolled actu	nstructions, I declare that I have ary, as well as the electronic ve	rsion of this return/r	eport, and to the b	est of my knowledge and
belief, it is true, correct, and		6-9-17	Scott Springe	r, D.O.	
Aut Aut	you be			ividual signing as p	olan administrator
Signature of plan	n administrator	Date 6-9-17	Scott Springe	r, D.O	
Signature of am	ployer/plan sponsor	Date	Enter name of ind	ividual signing as	employer or plan sponsor
Preparer's name (including Skip this question	firm name, if applicable) and addre	ess (include room or suite numb	per)	Skip thi	telephone number s question
OKIP LIIIS QUESTION					2
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	Form 5500-SF 2016		Page 2								
6a	Were all of the plan's assets during the plan year invested in eligible	assets? (	See instructions.)			•••••	•••••	•••••	X Yes	]No	
b	Are you claiming a waiver of the annual examination and report of ar	•			`	,				_	
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility ar							•••••	X Yes	No	
	If you answered "No" to either line 6a or line 6b, the plan cannot										
C —	If the plan is a defined benefit plan, is it covered under the PBGC ins	urance pr	ogram (see ERISA section	1 402	1)?		Yes	No	Not dete	rmined	
Pa	art III Financial Information										
7	Plan Assets and Liabilities		(a) Beginning of	Year	•			(b) End	of Year		
а	Total plan assets	7a	2:	72,9	08				212,40	<del>)</del> 9	
b	Total plan liabilities	7b			0			0			
С	Net plan assets (subtract line 7b from line 7a)	7c	2	72,9	08				212,46	)9	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount					(b) T	otal		
а	Contributions received or receivable from:	8a(1)			0						
	(1) Employers	8a(2)			0						
	(3) Others (including rollovers)	8a(3)			0						
b	Other income (loss)	8b		18,4							
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		10,7					18,46		
d	Benefits paid (including direct rollovers and insurance premiums								10,40		
	to provide benefits)	8d		78,4	23						
е	Certain deemed and/or corrective distributions (see instructions)	8e			0						
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f		4	82						
g	Other expenses	8g			0						
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							78,96	)5	
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i				_			(60,499	<u>))                                   </u>	
<u>_j_</u>	Transfers to (from) the plan (see instructions)	8j			0						
Pa	art IV Plan Characteristics										
9a	If the plan provides pension benefits, enter the applicable pension fe	ature code	es from the List of Plan Ch	aract	eristic	Code	s in the	e instruction	ons:		
	2E 2F 2G 2J 3D										
b	If the plan provides welfare benefits, enter the applicable welfare fea	ture codes	s from the List of Plan Cha	racte	ristic (	Codes	in the	instruction	ns:		
$\Box$											
	art V Compliance Questions										
<u>10</u>	During the plan year:		1		Yes	No	N/A		Amount		
а	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		•								
	described in 29 CFR 2510.3-102? (See instructions and DOL's Vol	,	,	100		х					
b	Program)  Were there any nonexempt transactions with any party-in-interest?			10a							
	reported on line 10a.)			10b		х					
C				10c	Х				56	9,000	
d											
	by fraud or dishonesty?			10d		Х					
е	Were any fees or commissions paid to any brokers, agents, or other carrier, insurance service, or other organization that provides some										
	the plan? (See instructions.)			10e	X				1	1,338	
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 as	of year e	nd.)	10g		х					
— h		-	·								
	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			10i							

_		l	
Page 3 -	I		

Part	VI	Pension Funding Compliance								
		a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and					Yes 🛚	No		
	(Form 5500 and line 11a below)									
12	Is this	a defined contribution plan subject to the minimum funding requirements of section 412 of the	Code or se				· [7			
		?es," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	•••••••	••••••	••••••		Yes X	∐ No		
а	If a wa	ver of the minimum funding standard for a prior year is being amortized in this plan year, see it		and ent	er the date	of the I	etter rul	ing		
		g the waiver			Day	Yea	ar			
		ne minimum required contribution for this plan year.		12b						
		ne amount contributed by the employer to the plan for the plan year								
		ct the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the								
		e amount)								
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								
		resolution to terminate the plan been adopted in any plan year?	••••••	•	Yes	Х	No			
		" enter the amount of any plan assets that reverted to the employer this year								
		Il the plan assets distributed to participants or beneficiaries, transferred to another plan, or bro of the PBGC?	J			Yes	X No	)		
		ng this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide assets or liabilities were transferred. (See instructions.)			•					
13	c(1) Na	me of plan(s):	13c(2)	EIN(s)		130	(3) PN	(s)		
Part	VIII	Trust Information - Skip These Questions								
	Name	•		14	<b>b</b> Trust's E	IN				
14c	Name	of trustee or custodian		14	<b>d</b> Trustee	or custo	dian's			
	· ·	or additional of additional of a data and a			telephon					
Part		IRS Compliance Questions - Skip These Questions	Τ							
15a	Is the p	lan a 401(k) plan? If "No," skip b.		Yes			No			
		d the plan satisfy the nondiscrimination requirements for employee deferrals under section		Design- safe ha			"Prior yetest	ear" ADP		
	401(K)(	3) for the plan year? Check all that apply:		"Currer						
				ADP te	•		N/A			
		esting method was used to satisfy the coverage requirements under section 410(b) for the plar Check all that apply:		Ratio percent test	age 🔲	Avera benefi	-	□ N/A		
		plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) plan year by combining this plan with any other plan under the permissive aggregation rules?	, II I	Yes			No			
	If the p	lan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IF er/ and serial number	RS opinion I	etter or a	advisory le	tter, ent	er the d	ate of		
	If the p	lan is an individually-designed plan that received a favorable determination letter from the IRS.	, enter the o	late of th	e most red	cent dete	erminati	on		
18	Define Were a	d Benefit Plan or Money Purchase Pension Plan Only: ny distributions made during the plan year to an employee who attained age 62 and had not s ?			☐ Yes		No			
		ny plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?	••••••	••••••	Yes		No			