## 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).

2016

This Form is Open to Public Inspection

OMB Nos. 1210-0110

1210-0089

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

b Total number of participants at the end of the plan year	Parti			016		2/24/2046						
A This return/report is for:    a one-participant plan   a foreign plan   a foreign plan   a foreign plan	For calenda	ar pian year 2016 or	needi pidii yedi zegiiiing									
B This return/report is	A Th:		a single-employer plan				-					
B This return/report is	A This ret	urn/report is for:	a one-participant plan		ipioyer information in ac	cordance w	vitri trie iorii	i instructions.)				
C Check box if filing under:    Form \$558				a loreign plan								
C Check box if filing under:    Form \$558	R This retu	ırn/renort is	the first return/report	the final return/report								
C Check box if filing under:	<b>3</b> 11115 1010	in proport is	- H	H	n/report (less than 12 m	onths)						
Part II   Basic Plan Information—enter all requested information   1a Name of plan   Ib Three-digit plan number (PN)				_	Wiebert (1000 than 12 m	_						
Part II   Basic Plan Information—enter all requested Information   1a Name of plan   WOODSTOCK PHYSICAL THERAPY DEFINED BENEFIT PENSION PLAN   1c Effective date of plan   OHO (12010)   2a Plan sponsor's name (employer, if for a single-employer plan)   Mailing address (include room, apit, suite no. and street, or P.O. Box)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Plan sponsor's name (employer, if for a single-employer plan)   OHO (12010)   2d Sponsor's telephone number (EIN)   OHO (12010)   2d Business code (see instructions)   2d Business code (see instructions)   3d Administrator's telephone number   4d EIN   3d Administrator's telephone number   4d EIN   3d Administrator's telephone number   4d EIN   4d PN   5a Total number of participants at the beginning of the plan year   5d Total number of participants at the beginning of the plan year   5d   OHO (12010)   5d   O	C Check b	oox if filing under:	Form 5558	automatic extension		DFVC p	rogram					
A Name of plan   WOODSTOCK PHYSICAL THERAPY DEFINED BENEFIT PENSION PLAN   1c Effective date of plan number (PN)   0.03   1c Effective date of plan number (PN)   0.03   1c Effective date of plan number (PN)   0.03   1c Effective date of plan number (PN)   2-3678810   2c Effective date of plan number (PN)   2c Effective date of pla			special extension (enter descri	iption)								
A Name of plan   WOODSTOCK PHYSICAL THERAPY DEFINED BENEFIT PENSION PLAN   1c Effective date of plan   003     1c Effective date of plan   003     1c Effective date of plan   0101/2010     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)     2c Sponsor's telephone number   845-679-2727     2d Business code (see instructions)   621340     3a Plan administrator's name and address   Same as Plan Sponsor.   3b Administrator's telephone number   845-679-2727     2d Business code (see instructions)   621340     3c Administrator's telephone number   845-679-2727     2d Business code (see instructions)   621340     3c Administrator's telephone number   845-679-2727     2d Business code (see instructions)   621340     3c Administrator's telephone number   845-679-2727     3d Administrator's telephone number   845-679-2727     4d Pin   845-879-2727     5d Pin   845-879-2727     5d Pin   845-879-2727     4d Pin   845-879-2727     4d Pin   845-879-2727     5d Pin   845-879-2727     5d Pin   845-879-2727     5d Pin   845-879-2727     5d Pin   845-879-2727     6d Pin   845-87272     6d Pin	Part II	Basic Plan Inf	ormation—enter all requested info	ormation								
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) WOODSTOCK PHYSICAL THERAPY  2b Employer Identification Number (EIN) 20-3678810  2c Sponsor's telephone number 845-679-2727  2d Business code (see instructions) 621340  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number name, EIN, and the plan number from the last return/report.  a Sponsor's name 4c 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 C Number of participants at the end of the plan year.  6d(1) 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 with accrued benefits that were less than 100% vested.  6d(2) Total number of active participants at the end of the plan year with accrued benefits that were less than 100% vested.  6d(2) Total number of active participants at the end of 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 with accrued benefits that were less than 100% vested.  6d(3) Total number of active participants at the end of the plan year with accrued benefits that were less than 100% vested.  6d(3) Total number of active participants at the end of this plan year with accrued benefits that were less than 100% vested.  6d(4) Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  6d(5) Ellied with authorized/valid electronic signature.  6d(6) Ellied with authorized/valid electronic signature.  6d(6) Ellied with authorized/valid electronic signature.  6d(6) Ellied with authorize	1a Name		·			1b Thre	e-digit					
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) WOODSTOCK PHYSICAL THERAPY  2c Sponsor's telephone number 84.6-79-277 2d Business code (see instructions) 82 Band administrator's name and address WOODSTOCK, NY 12498-8235  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's telephone number 8c Enloyed Pale Administrator 8c Administrator telephone number 8c Administrator's telephone number 8c Administrator's telephone	WOODSTOO	CK PHYSICAL THER	APY DEFINED BENEFIT PENSION	PLAN				000				
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) WOODSTOCK PHYSICAL THERAPY  2c Sponsor's telephone number 845-579-272 2d Business code (see instructions) 621340  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 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.  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.  5 Total number of participants at the beginning of the plan year.  5 D Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 Uniform of participants with account balances as of the end of the plan year.  6 Under penalize of participants at the terminated employment during the plan year with accrued benefits that were less than 100% vested.  7 Under penalize of penyl valor other penalizes set forth in the instructions, of declare that I have examined this return/report, including, if applicable, a Schedule SD or Schedule MBc 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 bellef, it is true, correct, and complete.  8 Signature of employer/plan sponsor  Date Enter name of individual signing as plan administrator						_ ` /						
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) WOODSTOCK PHYSICAL THERAPY  20 Business code (see instructions) 621340  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number and address 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  4c PN  5a Total number of participants at the beginning of the plan year. b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  4d(2) Total number of active participants at the hed of the plan year.  5c Clumber of participants at the minumber of the plan year.  4d(2) Total number of active participants at the beginning of the plan year.  5d(2) 7  6d(2) 7  7b Pound of the plan perticipants at the beginning of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants at the minumber of the plan year.  6d(2) Total number of active participants at the beginning of the plan year.  6d(2) Total number of active participants at the beginning of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  6d(2) Total number of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participants with account balances as of the end of the plan year.  5c Clumber of participa						1C Effec		•				
City of town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  2c Sponsor's telephone number 845-679-2727  2d Business code (see instructions) 621340  3a Plan administrator's name and address  Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number 821340  4 If the name and/or EIN of the plan sponsor has changed since the last return/report filled for this plan, enter the name, EIN, and the plan number from the last return/report.  4 Sponsor's name  4 C PN  5a Total number of participants at the beginning of the plan year	2a Plan sp	oonsor's name (empl	oyer, if for a single-employer plan)			<b>2b</b> Empl	loyer Identif	ication Number				
### Additional Participants at the beginning of the plan year complete this tiem).  ### Comparison of the plan year complete this implicants at the beginning of the plan year with account balances as of the end of the plan year with account bal						(EIN)	20-36	378810				
PO BOX 1225 WOODSTOCK, NY 12498-8235  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				ai code (il foreign, see instr	uctions)	2c Spor						
A 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 Description of the plan number of participants at the beginning of the plan year.  5 Description of the plan year of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 Description of the plan year of participants at the beginning of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 Description of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 Description of the plan year with account balances as of the end of the plan year (only defined contribution plans to be plan year (only defined contribution plans to be plan year (only defined contribution plans that the definition of the plan year with account balances are plant to be plan year (only defined contribution plans that the plant year with account balances are plant to be plant year of participants at the end of the plan year (only defined contribution plans that the plant year with accrued benefits that were less than 100% vested.  6 Description of the plant year with accrued benefits that were less than 100% vested.  7 Description of this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic vesion of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  8 Signature of plan administrator  8 Date Enter name of individual signing as plan administrator  9 Date Enter name of individual signing as employer or plan sponsor		ACT THE OTOTAL THE IC					845-679	-2727				
3a Plan administrator's name and address Same as Plan Sponsor.  3b 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.  4 Sponsor's name  5a Total number of participants at the beginning of the plan year	DO DOV 400	_				<b>2d</b> Busir	ness 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.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year							6213	40				
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.  Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year												
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.  Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year	3a Plan a	dministrator's name a	and address X Same, as Plan Spon	sor		<b>3b</b> Admi	inistrator's F	=IN				
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  4c PN  5a Total number of participants at the beginning of the plan year	ou manu	Than daminionator o hamo dirid discrete do Fran oponion.						, tanimistrator o Ent				
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year						<b>3c</b> Administrator's telephone number						
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year												
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												
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												
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a 7  Total number of participants at the beginning of the plan year	4 If the r	name and/or EIN of the	ne plan sponsor has changed since t	the last return/report filed for	or this plan, enter the	4b EIN						
Total number of participants at the beginning of the plan year					•	10 2.11						
b Total number of participants at the end of the plan year	<b>a</b> Sponso	or's name										
C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>5a</b> Total r	number of participant	s at the beginning of the plan year					7				
d(1) Total number of active participants at the beginning of the plan year	<b>b</b> Total r	number of participant	s at the end of the plan year			5b		8				
d(1) Total number of active participants at the beginning of the plan year				. , , ,	•	5c						
d(2) Total number of active participants at the end of the plan year	compl	ete this item)										
Pumber 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 HERE  Filed with authorized/valid electronic signature.  O6/06/2017  ELLEN R. KRAMER  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	<b>d(1)</b> Tota	al number of active p	articipants at the beginning of the pla	an year								
than 100% vested	<b>d(2)</b> Tota	al number of active p	articipants at the end of the plan yea	ır		5d(2)		7				
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  Signature of plan administrator  Date  Enter name of individual signing as employer or plan sponsor  Date  Enter name of individual signing as employer or plan sponsor						5e		0				
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.   06/06/2017   ELLEN R. KRAMER	Caution: A	penalty for the late	or incomplete filing of this return	/report will be assessed	unless reasonable cau	use is estal	blished.					
belief, it is true, correct, and complete.  SIGN 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												
Signature of plan administrator   Date   Enter name of individual signing as plan administrator				s well as the electronic ver	sion of this return/repor	t, and to the	e best of 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				06/06/2017	ELLEN R. KRAMER							
SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor				Data	Enter name of individ	ual aigning	00 000 000	ainiatratar				
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor		orginature of plan	aummstrator	Date	Enter hame of individ	uai signing	as pian adn	าแกรแสเบเ				
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												
	Preparer's	name (including firm	name, if applicable) and address (in	clude room or suite numbe	er)	Preparer's	s telephone	number				

Form 5500-SF 2016 Page **2** 

	Were all of the plan's assets during the plan year invested in eligib								XY	es No
b	Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility		XY	es No						
	If you answered "No" to either line 6a or line 6b, the plan cann		,						_	
С	If the plan is a defined benefit plan, is it covered under the PBGC in	nsurance p	orogram (see ERISA se	ection 4	021)?		Yes	X No	Not d	etermined
Pa	rt III Financial Information		·							
7	Plan Assets and Liabilities		(a) Beginning (	of Year			(	(b) End	of Year	
<u>a</u>	Total plan assets	7a	:	362245	5				4613	397
b	Total plan liabilities	7b								
<u> </u>	Net plan assets (subtract line 7b from line 7a)	7c	;	362245					4613	397
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt				(b) T	otal	
а	Contributions received or receivable from: (1) Employers	8a(1)		70000						
	(2) Participants	8a(2)		0						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)		29152	2						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)							991	52	
d	Benefits paid (including direct rollovers and insurance premiums	8c								
	to provide benefits)	8d			_					
<u>e</u>	Certain deemed and/or corrective distributions (see instructions).	8e								
f	Administrative service providers (salaries, fees, commissions)	8f		C						
<u>g</u>	Other expenses	8g		С						
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							004	0
<del>_</del> i	Net income (loss) (subtract line 8h from line 8c)	8i							991	152
	Transfers to (from) the plan (see instructions)	8j								
	t IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension $\stackrel{1}{\text{D}}$	feature co	odes from the List of Plant	an Cha	racteri	stic Co	odes in	the inst	ructions:	
b	If the plan provides welfare benefits, enter the applicable welfare f	eature cod	les from the List of Pla	n Chara	acterist	ic Cod	des in t	he instru	uctions:	
Par	t V Compliance Questions									
10	During the plan year:				Yes	No	N/A		Amoui	nt
а	Was there a failure to transmit to the plan any participant contributes described in 29 CFR 2510.3-102? (See instructions and DOL's Normal)	oluntary F	iduciary Correction	10a		X				
b	9 ,	t? (Do not	include transactions	10b		X				
С	Was the plan covered by a fidelity bond?			10c		X				
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.)									
f	f Has the plan failed to provide any benefit when due under the plan?									
g	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)									
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)	•		10h						
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						

Page 3-	1	

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)					X	'es No		
	Ente	r the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40			11a		•	0		
12		is a defined contribution plan subject to the minimum funding requirements of section 412 of the Co A?					□\	′es X No		
	(If "	es," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)								
a		raiver of the minimum funding standard for a prior year is being amortized in this plan year, see ins ing the waiver		s, and	l enter t _ Day		of the lette Year _	r ruling		
If	you c	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.	1		ī				
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		ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the l tive amount)			12d					
		he 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	a resolution to terminate the plan been adopted in any plan year?				Yes	s X N	0		
	If "Y€	es," 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 brougo ol of the PBGC?					Yes X	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 pl	an(s)	n(s) to					
	13c(1)	Name of plan(s):	1	3c(2)	EIN(s)		13c(3	<b>)</b> PN(s)		
Part	VIII	Trust Information								
14a	Name	of trust			<b>14b</b> Trust's EIN					
14c	Name	of trustee or custodian					s or custod ne number	ian's		
Par	t IX	IRS Compliance Questions								
15a	Is the	plan a 401(k) plan? If "No," skip b		Yes			No			
		did the plan satisfy the nondiscrimination requirements for employee deferrals under section (3) for the plan year? Check all that apply:	L  s		n-based arbor	d [	Prior ye test	ear" ADP		
			-  □ "	Curre ADP t	ent year est	,,	N/A			
16a 		testing method was used to satisfy the coverage requirements under section 410(b) for the plan Check all that apply:	🗌	Ratio perce test	entage		verage enefit test	N/A		
	for the	be plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) be plan year by combining this plan with any other plan under the permissive aggregation rules?		Yes			No			
	the le									
	letter	plan is an individually-designed plan that received a favorable determination letter from the IRS, en/	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?		om	Ye	s [	No			
19	Was	any plan participant a 5% owner who had attained at least age 70 $^{1\!\!/}_2$ during the prior plan year?			Ye	s	No			

# SCHEDULE SB (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Single-Employer Defined Benefit Plan Actuarial Information

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).

File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

Fc	or calendar plan year 2016 or fiscal plan year beginning 01/01/2016		and ending	g 12/	31/2016	
	Round off amounts to nearest dollar.  Caution: A penalty of \$1,000 will be assessed for late filing of this report un	lless reasonable o	cause is established	 d.		
Α	Name of plan WOODSTOCK PHYSICAL THERAPY DEFINED BENEFIT PENSION PLAN		<b>B</b> Three-diç	git	J) •	003
	Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF WOODSTOCK PHYSICAL THERAPY		<b>D</b> Employer	Identific 20-36	ation Number (E 78810	EIN)
Е	Type of plan: X Single Multiple-A Multiple-B	Prior year plan size	: X 100 or fewer	101	-500 More th	an 500
F	Part I Basic Information	<u> </u>			<u>L-1</u>	
1		Year <u>2016</u>				
2	Assets:					
	a Market value			2a		361226
	<b>b</b> Actuarial value			2b		361226
3	Funding target/participant count breakdown	Number of participants	` '	sted Funding Target	(3) Total Funding Target	
	<b>a</b> For retired participants and beneficiaries receiving payment	0	0		0	
	<b>b</b> For terminated vested participants		1		0	0
	C For active participants	7		366604	366604	
	<b>d</b> Total		8		366604	366604
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)	)	🗍			
	a Funding target disregarding prescribed at-risk assumptions			4a		
	<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition status for fewer than five consecutive years and disregarding loading fa					
5	Effective interest rate			5		6.05%
6	Target normal cost			6		59973
	atement by Enrolled Actuary  To the best of my knowledge, the information supplied in this schedule and accompanying schedules accordance with applicable law and regulations. In my opinion, each other assumption is reasonable combination, offer my best estimate of anticipated experience under the plan.					
	SIGN HERE				06/12/201	7
	Signature of actuary				Date	
	THEODORE ANDERSEN, M.A.A.A, M.S.P.A				17-02034	
	Type or print name of actuary			Most	recent enrollmer	nt number
F	PENSION ASSOCIATES				203-356-03	06
	Firm name 2001 WEST MAIN STREET, SUITE 230 STAMFORD, CT 06902-4556		Te	lephone	number (includ	ing area code)
	Address of the firm					
	ne actuary has not fully reflected any regulation or ruling promulgated under the	ne statute in comp	eleting this schedule	e, check	the box and see	e [

Page	2 -	1
age	<b>Z</b> -	Т.

Pa	art II	Begin	ning of Year	Carryov	er and Prefunding Ba	alances									
	•							(a) C	arryover balance		<b>(b)</b> P	refundir	ng balance		
		-	•		able adjustments (line 13 fro	•			C	)			0		
8			•	-	nding requirement (line 35 fr	•			C	)			0		
9	Amount	remaining	g (line 7 minus line	e 8)					C	)			0		
10	Interest	on line 9 ı	using prior year's	actual retu	rn of <del>-3.64</del> %		-		C	)			0		
11	Prior yea	ar's exces	s contributions to	be added	to prefunding balance:										
					38a from prior year)								14640		
	` Sc	hedule SI	B, using prior year	's effective	a over line 38b from prior year e interest rate of6.31 9	%							924		
					Schedule SB, using prior year's actual							0			
	<b>C</b> Total a	vailable a	t beginning of curre	ent plan yea	ar to add to prefunding balance	·							15564		
	<b>d</b> Portio	n of (c) to	be added to prefu	unding bala	ance								0		
12 Other reductions in balances due			n balances due to	elections	or deemed elections				C	)			0		
13 Balance at beginning of current y				r (line 9 +	line 10 + line 11d – line 12) .				C	)			0		
Part III Funding Percentages															
14	14 Funding target attainment percentage									14	98.53%				
	15 Adjusted funding target attainment percentage										15	98.53%			
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement								current	16	114.24%					
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage									17	%					
Р	art IV	Con	tributions an	d Liquid	lity Shortfalls										
18	Contribu				ar by employer(s) and emplo	yees:									
	(a) Dat //M-DD-Y		<b>(b)</b> Amount p employer		(c) Amount paid by		(a) Date (b) Amount paid employer(s)				(c	-	ount paid by ployees		
	5/23/2017		employen	70000	employees 0	(IVIIVI-L	ז -טי	111)	employer(	5)		empic	Dyees		
	0/20/2011			. 5555											
						Totals 1	<u> </u>	18(b)		70000	18(c)		0		
19					uctions for small plan with a										
	_			•	num required contributions f					19a			0		
				_	usted to valuation date					19b			0		
20					red contribution for current ye	ar adjusted	to va	aluation d	ate	19c			64515		
20			itions and liquidity		e prior year?								Vec V No		
			_		installments for the current y							□	Yes X No Yes No		
				. ,	nplete the following table as			uniciy illa	aiıi(Cl :			⊔	Yes   No		
	• II IIIIe	20015 f	co, oce monucilo	no anu cor	Liquidity shortfall as of end			his plan v	/ear						
		(1) 1s	t		(2) 2nd	1 10			3rd		(4) 4th				

Б	Part V Assumptions Used to Determine Funding Target and Target Normal Cost							
21								
	a Segment rates: 1st segment: 2nd segment: 3rd segmen	t:						
	4.43% 5.91% 6.65		N/A, full yield curve used					
	<b>b</b> Applicable month (enter code)	21b	0					
22	Weighted average retirement age	<b>22</b>	68					
23	Mortality table(s) (see instructions)	Substit	ute					
Pa	art VI Miscellaneous Items							
	Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see	instruction	ns regarding required					
	attachment							
25	Lies a method change have made for the augment plan year? If "Vee " and instructions regarding required atta	ahmant	Yes ⊠ No					
	Has a method change been made for the current plan year? If "Yes," see instructions regarding required attached	Jillient						
26	Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required	attachme	ntYes X No					
27	3 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	27						
_	attachment							
	art VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years		1					
	Unpaid minimum required contributions for all prior years	28	0					
29	Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0					
30	Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0					
Pa	art VIII Minimum Required Contribution For Current Year							
31	Target normal cost and excess assets (see instructions):							
	a Target normal cost (line 6)	31a	59973					
	<b>b</b> Excess assets, if applicable, but not greater than line 31a	31b	0					
32	Amortization installments: Outstanding Ba	ance	Installment					
	a Net shortfall amortization installment	5378	889					
	<b>b</b> Waiver amortization installment	0	0					
33	If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval	33	0					
	(Month Day Year ) and the waived amount		60862					
34	Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)	34						
	Carryover balance Prefunding bala	ance	Total balance					
35	Balances elected for use to offset funding	0	0					
	i oqui o i o i o i o i o i o i o i o i o i o		-					
	Additional cash requirement (line 34 minus line 35)	36	60862					
31	Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	64515					
38	Present value of excess contributions for current year (see instructions)		1					
	a Total (excess, if any, of line 37 over line 36)	38a	3653					
	<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0					
39	Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0					
40	40 Unpaid minimum required contributions for all years							
Pa	rt IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instruction	s)						
41	If an election was made to use PRA 2010 funding relief for this plan:							
	a Schedule elected							
	<b>b</b> Eligible plan year(s) for which the election in line 41a was made		008					
42	Amount of acceleration adjustment							
	Excess installment acceleration amount to be carried over to future plan years	43						

#### 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).

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

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

	calendar plan year 2016 or fi	t Identification Information iscal plan year beginning		01/2016	and ending	12/3	31/2016	
		x a single-employer plan			lan (not multiemployer)			x must attach
Α	This return/report is for:		a list of p	participating e	mployer information in a			
_	This return from est in.	a one-participant plan	a foreign	•				
D	This return/report is:	the first return/report	H	return/report		41 \		
		an amended return/report	☐ a snort p	olan year retu	n/report (less than 12 m	ionins)		
С	Check box if filing under:	Form 5558	automat	ic extension			DFVC progra	ım
		special extension (enter descr	ription)					
F	art II Basic Plan Info	ormation enter all requested	information					
1a	Name of plan						ree-digit in number	
	Woodstock Physical	Therapy Defined Benefi	t Pension	Plan			v) ►	003
						100	ective date o	f plan
2a		oyer, if for a single-employer plan)				2b Em	ployer Identi	fication Number
		om, apt., suite no. and street, or P.0 ace, country, and ZIP or foreign post		eign, see inst	ructions)	(EI	N) 20-36	78810
	Woodstock Physical	Therapy					onsor's telepi	hone number
					(see instructions)			
	PO Box 1235						1340	(000 monacatomo)
	US Woodstock NY 12498-8	235						
3a		and address X Same as Plan Spe	onsor	**		3b Ad	ministrator's	EIN
						3c Ad	ministrator's	telephone number
4	If the name and/or EIN of th	ne plan sponsor has changed since	the last return	/report filed fe	or this plan, enter the	4b EI	١	
	name, EIN, and the plan nu	imber from the last return/report.		,				
	Sponsor's name					4c PN	<u> </u>	
-		s at the beginning of the plan year				5a 5b		7 8
b		s at the end of the plan year account balances as of the end of						8
·						5c		
d	(1) Total number of active pa	articipants at the beginning of the pla	an year			5d(1)		7
d	(2) Total number of active pa	articipants at the end of the plan yea	ar	••••••	,,,,,,	5d(2)		7
е	Number of participants that less than 100% vested	terminated employment during the				5e		0
_Ca	aution: A penalty for the late	e or incomplete filing of this retur	rn/report will	be assessed	unless reasonable ca	use is est	ablished.	
		other penalties set forth in the instru						
	B or Schedule MB completed lief, it is true, correct and cor	and signed by an enrolled actuary, pelete.	as well as the	electronic ve	rsion of this return/repor	t, and to th	ne best of my	knowledge and
1.4	9//11//	10/11/1	101	1/1/19	Ellen R. Kramer			
	IGN Signature of plan add	ministrator	Date	4//	Enter name of individu		as plan admi	nietrator
	1/11/10	<del>/</del>	Ca	16/12	Ellen R. Kramer		as plair aurili	riistrator
	IGN - 6/64 - 4 - 1	Mil	-   <i>(C)</i>	14/17				
	Preparer's name (including firm name, if applicable) and address (include room or suite number)						as employer	
S	Skip this question						his quest	
								<b>"好"的"</b> "
L						1.4	7-	

	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 a							_	
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a							<u> </u>	Yes No
С	If you answered "No" to either line 6a or line 6b, the plan cannot lift the plan is a defined benefit plan, is it covered under the PBGC installation.							V No F	Not determine
		surance pr	ogram (see EntoA section	1702	1):			<u> </u>	1 Not determine
	Financial Information	E-de La	(a) Beginning of	Vac		Т	/b	) End of Y	'oor
<u>/</u>	Plan Assets and Liabilities Total plan seests	7a	<del></del>	2,2		+-	(0)	) End of 1	461,397
b	Total plan assets	7b	30	2,2	13	╁		-	401,391
c	Net plan assets (subtract line 7b from line 7a)	7c	36	2,2	45	T			461,397
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount			1		(b) Tota	
а	Contributions received or receivable from:			0 0	20	4	Maria		
_	(1) Employers	8a(1)		0,00	0		A No.	7,5 %	Belonia
-	(2) Participants	8a(2)					1 mg 1 mg	4 Z - 14	Language March
b	(3) Others (including rollovers)  Other income (loss)	8a(3) 8b	2	9,1	52			Ties jan	
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				(SINO)	A ROBERT STATE		99,152
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d					je j		
е	Certain deemed and/or corrective distributions (see instructions)	8e					1.00		(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f			0				A May 1
g	Other expenses	8g			0		41741	7 4 2	<b>.</b>
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							0
Ļ	Net income (loss) (subtract line 8h from line 8c)	8i_	NEW TRANSPORT		1		ar area of the second	96.0	99,152
	Transfers to (from) the plan (see instructions)	8j	<u> </u>				1	Martin Plant	e en la company
	Plan Characteristics		- f 1 - 1 - 1 - 1 - 1 - 1 - 1						
9a	If the plan provides pension benefits, enter the applicable pension for 1D	eature code	es from the List of Plan Ch	aracti	eristic	Cod	es in the in	structions	
b	If the plan provides welfare benefits, enter the applicable welfare fea	ture codes	s from the List of Plan Cha	racte	ristic (	Çode	s in the ins	tructions:	
P	Compliance Questions								
10	During the plan year:				Yes	No	N/A	Am	ount
а									
	described in 29 CFR 2510.3-102? (See instructions and DOL's Vo	(5)		10a		x			
b				104		-	#101E-01		
	reported on line 10a.)			10b		X	<i>(19</i> )	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				10c		X	-1. jh		
	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						= = = = 10,		
	the plan? (See instructions.)		10e		X				
f	The second secon		10f		X				
<u>g</u>	If this is an individual account plan, was there a blackout period? (	See instru	ctions and 29 CFR	10g		х			
	2520.101-3.)			10h				18. 97.	
- 1	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i					

	Form 5500-SF 2016		Page 3 -									
	10111 0000-01 2010		r age 🗸									
Par	Pension Funding Compliance											
11	Is this a defined benefit plan subject to minimum funding (Form 5500 and line 11a below)							X	Yes [	<b>□</b>	Vo	
11a	Enter the unpaid minimum required contributions for all y					11a					0	
12	Is this a defined contribution plan subject to the minimun ERISA?								Yes [	X N	No	
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and								ar nor			
а	If a waiver of the minimum funding standard for a prior ye granting the waiver		50			and enter			letter ru ar	ling		
lf y	you completed line 12a, complete lines 3, 9, and 10 of 5								aı			
b	Enter the minimum required contribution for this plan yea					12b						
С	Enter the amount contributed by the employer to the plan	for the plan year				12c						
d	Subtract the amount in line 12c from the amount in line 1 negative amount)	manage to respond the restriction recognition of the recognition of				12d						
е	Will the minimum funding amount reported on line 12d be	met by the funding deadling	ne?				Yes [	No		√A		
Par	Plan Terminations and Transfers of	Assets										
13a	Has a resolution to terminate the plan been adopted in a	ny plan year?				. [	Yes	х	No			
	If "Yes," enter the amount of any plan assets that reverte	d to the employer this year	***************************************			. 13a						
b	<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under to control of the PBGC?								X N	0		
С	If, during this plan year, any assets or liabilities were tran which assets or liabilities were transferred. (See instruction	sferred from this plan to an										
1	3c(1) Name of plan(s):				13c(2)	EIN(s)	IN(s) 13c(3) PN(s)					
<b>建</b> 基层系统												
Ear	Trust Information - Skip These Ques	stions										
14a	I Name of trust					14b	Trust's E	IN				
140	Name of trustee or custodian				,,,	5 10000	Trustee o					
ear	IRS Compliance Questions - Skip Th	nese Questions										
15a	I Is the plan a 401(k) plan? If "No," skip b.		••••••			Yes			No			
15b	How did the plan satisfy the nondiscrimination requireme 401(k)(3) for the plan year? Check all that apply:	nts for employee deferrals				Design-b safe harb			"Prior y test	ear".	ADP	
						"Current ADP test	year"		N/A			
16a	16a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:							Avera	age fit 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			
17a	If the plan is a master and prototype plan (M&P) or volume the letter// and serial number	ne submitter plan that recei	ved a favoral	ble IRS	opinion I	etter or ad	visory le	tter, en	ter the c	date c	)f	
17t	If the plan is an individually-designed plan that received a	favorable determination le	tter from the	IRS A	nter the c	ate of the	most rec	ent de	terminat	ion	-	

Yes No

Yes No

Defined Benefit Plan or Money Purchase Pension Plan Only:
Were any distributions made during the plan year to an employee who attained age 62 and had not separated from

19 Was any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?

## **SCHEDULE SB** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security Administration** Pension Benefit Guaranty Corporation

## Single-Employer Defined Benefit Plan **Actuarial Information**

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).

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

	r rile as an attachin	ient to i onni 3300 or 4	JJ00-31 .				
For ca	lendar plan year 2016 or fiscal plan year beginning 01/03	1/2016	and ending	g 12	/31/20	16	
▶ Ro	und off amounts to nearest dollar.						
▶ Ca	ution: A penalty of \$1,000 will be assessed for late filing of this report	unless reasonable car	use is established				
A Nar	ne of plan		B Three-digi	t			
Woods	tock Physical Therapy Defined Benefit Pension	Plan	plan numb	er (PN)	<b>&gt;</b>		003
C Plai	sponsor's name as shown on line 2a of Form 5500 or 5500-SF		D Employer Ide	entificat	ion Num	ber (E	EIN)
Woods	tock Physical Therapy		20	0-3678	8810		
Е Тур	e of plan: Single Multiple-A Multiple-B	Prior year plan size:	X 100 or fewer	]101-5	00 🔲	More	than 500
Pari	I Basic Information						
1 E	nter the valuation date: Month 01 Day 01	L Year2016	_				
2 /	ssets:						
а	Market value			2a			361,226
b	Actuarial value			2b			361,226
<b>3</b> F	unding target/participant count breakdown:	(1) Number of participants	<del></del>				(3) Total Funding Target
•	For retired participants and beneficiaries receiving payment	0			0		0
		1		0			0
	For terminated vested participants	7	366,604			366,604	
	For active participants	8		366,604			366,604
	Totalthe plan is in at-risk status, check the box and complete lines (a) and			500			300,001
	Funding target disregarding prescribed at-risk assumptions	252.90		4a			
	Funding target reflecting at-risk assumptions, but disregarding transi						
L	at-risk status for fewer than five consecutive years and disregarding			4b			
5 E	ffective interest rate			5	6.05 %		
<b>6</b> T	arget normal cost			6			59,973
To the accord	nent by Enrolled Actuary best of my knowledge, the information supplied in this schedule and accompanying schedule ance with applicable law and regulations. In my opinion, each other assumption is reasonable ation, offer my best estimate of anticipated experience under the plan.	es, statements and attachmen e (taking into account the expe	ts, if any, is complete ar erience of the plan and	nd accurat reasonabl	e. Each pre e expectati	esribed ons) an	assumption was applied in d such other assumptions, in
SIC					06/12	/201	7
	Signature of actuary				D	ate	
Theodore Andersen, M.A.A.A, M.S.P.A 17-02034							
	Type or print name of actuary			Most re	ecent en	rollme	ent number
	Pension Associates			(20	3) 35	6-03	306
	Firm name		Tel	ephone	number	(inclu	iding area code)
	2001 West Main Street, Suite 230						
	US Stamford CT 06902-4556						
	Address of the firm						
If the ac	tuary has not fully reflected any regulation or ruling promulgated unde	er the statute in comple	eting this schedule	e, check	the box	and s	see

	Schedu	le SB (Form 5500) 2016		Page 2	2				
Pa	rt II Bed	ginning of Year Carryov	ver and Prefunding Bal	ances					
		,g	<u> </u>		(a) (	Carryover balance	(b)	Prefundii	ng balance
7		eginning of prior year after appl				0			0
8		ed for use to offset prior year's				0			0
9	Amount rema	aining (line 7 minus line 8)	• • • • • • • • • • • • • • • • • • • •			0			0
10	Interest on lin	ne 9 using prior year's actual re	turn of			0			0
11	Prior year's e	xcess contributions to be adde	d to prefunding balance:						
	a Present va	alue of excess contributions (lir	e 38a from prior year)						14,640
	` '	t on the excess, if any, of line 3 ule SB, using prior year's effect	· ·						924
		t on line 38b from prior year Sc	- · · · · · · · · · · · · · · · · · · ·						0
	C Total avail	lable at beginning of current pla	an year to add to prefunding ba	alance .					15,564
	<b>d</b> Portion of	(c) to be added to prefunding b	alance						0
12	Other reducti	ons in balances due to electior	s or deemed elections			0			0
13	Balance at be	eginning of current year (line 9	+ line 10 + line 11d - line 12) •			0			0
Pa	rt III F	unding Percentages							
14	Funding targe	et attainment percentage	• • • • • • • • • • • • • • • • • • • •	•••••	• • • • • • • • • • • • • • • • • • • •	• • • • • • • • • • • • • • • • • • • •		14	98.53 %
15	Adjusted fund	ding target attainment percenta	ge			• • • • • • • • • • • • • • • • • • • •		15	98.53 %
16		unding percentage for purposes funding requirement						16	114.24 %
_17	If the current	value of the assets of the plan	is less than 70 percent of the f	unding tar	get, enter s	such percentage		17	%
Pa	rt IV C	ontributions and Liquid	dity Shortfalls						
18	Contributions	made to the plan for the plan	ear by employer(s) and emplo	yees:					
(MI	(a) Date M-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		) Date D-YYYY)	(b) Amount paid b employer(s)			
05/	/23/2017	70,000							

					_					
				Totals ►	18(b)		70,00	0 18(c)		0
19	Discounted e	employer contributions see in	structions for small plan with a	valuation dat	te after	the beginning of th	ne year:			
a Contributions allocated toward unpaid minimum required contributions from prior years							19a	0		
<b>b</b> Contributions made to avoid restrictions adjusted to valuation date						19b	C			
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date 19						19c			64,515	
20	20 Quarterly contributions and liquidity shortfalls:									
	a Did the plan have a "funding shortfall" for the prior year?							X No		
	<b>b</b> If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?								₃ ☐ 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
(2) 2nd (3) 3rd

(1) 1st

4th

(4)

Pa	art V	Assumption	ons Used To Determine	Funding Target and Targ	jet Normal Cost			
21	Discou	unt rate:						
	<b>a</b> Se	gment rates:	1st segment: 4.43 %	2nd segment: 5.91 %	3rd segment: 6.65 %	, 0	N/A, full yield curve used	
	<b>b</b> App	plicable month	(enter code)			21b	0	
22	Weigh	nted average re	tirement age			22	68	
23	Mortal	lity table(s) (see	e instructions) X Pr	rescribed - combined Pres	scribed - separate	Substitu	te	
Pa	rt VI	Miscellane	eous items					
24	Has a	change been r	made in the non-prescribed act	tuarial assumptions for the current	plan year? If "Yes," see	instruction	s regarding required	
25	Has a	method chang	e been made for the current pl	an year? If "Yes," see instructions	regarding required attac	hment .	Yes X No	
26	Is the	plan required to	o provide a Schedule of Active	Participants? If "Yes," see instruc	tions regarding required	attachmen	t Yes X No	
<u>27</u>			•	ter applicable code and see instruc		27		
Pa	rt VII	Reconcili	ation of Unpaid Minimu	um Required Contribution	s For Prior Years			
_28	Unpai	d minimum req	uired contributions for all prior	years		28	0	
29				d unpaid minimum required contrib		29	0	
30	Rema	ining amount o	f unpaid minimum required cor	ntributions (line 28 minus line 29)		30	0	
Pa	rt VIII	Minimum	<b>Required Contribution</b>	For Current Year				
31	Targe	t normal cost a	nd excess assets (see instruct	ions):				
	<b>a</b> Targ	get normal cost	(line 6)	• • • • • • • • • • • • • • • • • • • •		31a	59,973	
	<b>b</b> Exce	ess assets, if a	pplicable, but not greater than	line 31a		31b	0	
32	Amort	ization installm	ents:		Outstanding Bala	ance	Installment	
	<b>a</b> Net	shortfall amorti	ization installment	• • • • • • • • • • • • • • • • • • • •		5,378	889	
	<b>b</b> Wai	ver amortizatio	n installment	• • • • • • • • • • • • • • • • • • • •		0	0	
33				nter the date of the ruling letter gran		33	0	
34	Total f	unding requirer	ment before reflecting carryove	r/prefunding balances (lines 31a - 3	1b + 32a + 32b - 33)	34	60,862	
				Carryover balance	Prefunding Bala	ance	Total balance	
35			use to offset funding					
	require	ement	• • • • • • • • • • • • •	0		0	0	
36				• • • • • • • • • • • • • • • • • • • •		36	60,862	
37			•	ontribution for current year adjuste		37	64,515	
38								
	38 Present value of excess contributions for current year (see instructions)  a Total (excess, if any, of line 37 over line 36)							
	b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances  38b							
	39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) 39							
40	Unpai	d minimum req	uired contributions for all years	5		40	0	
	rt IX			Pension Relief Act of 2010		<b>5)</b>		
41	If an ele	ection was mad	de to use PRA 2010 funding re	lief for this plan:				
	<b>a</b> Schedule elected							
	_			41a was made				
42			·	·····		42		
				d over to future plan years		43		
				<u>.</u>			l	

# Schedule SB, Part V Summary of Plan Provisions

#### Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003

For the plan year 01/01/2016 through 12/31/2016

Employer: Woodstock Physical Therapy

Type of Entity - C-Corporation

EIN: 20-3678810 TIN: Plan #: 003 Plan Type: Defined Benefit

Dates: Effective - 01/01/2010 Year end - 12/31/2016 Valuation - 01/01/2016

Top Heavy Years - 2012, 2013, 2014, 2015, 2016

Eligibility: All employees excluding non-resident aliens, members of an excluded class and union

Minimum age - 21 Months of service - 12

Hours Required for - Eligibility - 1000 Benefit accrual - 500 Vesting - 1000

Plan Entry - First day of 1st or 7th month of plan year on or next following eligibility satisfaction

Retirement: Normal - Attainment of age 65 and completion of 10 years of participation

Early - Not provided

**Average Compensation:** Highest 3 consecutive years of service

Top Heavy Minimum Benefit - Highest 5 consecutive top heavy years of participation

Plan Benefits: Retirement - Derived from the graded benefit formula below rounded to the nearest dollar:

Employee Classification Benefit Formula

001 7.5% of average monthly compensation per year of participation beginning year

1 limited to 10 year(s) minus Floor Offset

002 0.5% of average monthly compensation per year of participation beginning year

1 limited to 50 year(s) minus Floor Offset

003 0.5% of average monthly compensation per year of participation beginning year

1 limited to 50 year(s) minus Floor Offset

Accrued Benefit - Unit credit based on participation

Minimum Benefit - None Maximum Benefit - None

Maximum allowable distribution is lump sum equivalent of normal form not to exceed 415 maximum allowable distribution, which is the lesser amount computed using a) 5.5% interest and the Applicable Mortality Table or

b) the greater of plan actuarial equivalence interest and mortality or 417(e) Minimum

Death Benefit - Face Amount minus Cash Value plus Present Value of Accrued Benefit

Top Heavy Minimum: Provided in another plan

IRS Limitations: 415 Limits - Percent: 100 Dollar: \$210,000

Maximum 401(a)(17) compensation - \$265,000

Normal Form: Life Annuity

Optional Forms: Lump Sum

Life Annuity Guaranteed for 10 Years

Joint with 50%, 75% or 100% Survivor Benefit

# Schedule SB, Part V Summary of Plan Provisions

#### Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003

For the plan year 01/01/2016 through 12/31/2016

Vesting Schedule:	Years	Percent
	0-1	0%
	2	20%

2 20% 3 40% 4 60% 5 80%

6 100%

Service is calculated using all years of service

Present Value of Accrued Benefit: Based on the greater of 417(e) or Actuarial Equivalence

417(e):

Interest Rates -

Segment #	Years	Rate %
Segment 1	0 - 5	1.82
Segment 2	6 - 20	4.12
Segment 3	> 20	5.01

Mortality Table - 16E - 2016 Applicable Mortality Table for 417(e) (unisex)

**Actuarial Equivalence:** 

Pre-Retirement - Interest - 5%

Mortality Table - None

Post-Retirement - Interest - 5%

Mortality Table - 16E - 2016 Applicable Mortality Table for 417(e) (unisex)

# Schedule SB, Part V Statement of Actuarial Assumptions/Methods

#### Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003

For the plan year 01/01/2016 through 12/31/2016

Valuation Date: 01/01/2016

Funding Method: As prescribed in IRC Section 430

Age - Eligibility age at last birthday and other ages at last birthday

New participants are included in current year's valuation

Prospective Compensation - Highest 3 consecutive years of service

Form of Payment - Assumed form of payment for funding is Life Annuity

Interest Rates -

Segment rates for the Valuation Date as permitted under IRC 430(h)(2)(C)

Segment #	Year	Rate %
Segment 1	0 - 5	1.41
Segment 2	6 - 20	3.96
Segment 3	> 20	4.97

Segment rates as of September 30, 2015 As permitted under IRC 430(h)(2)(C)(iv)(II) -

Segment #	Year	Rate %
Segment 1	0 - 5	4.43
Segment 2	6 - 20	5.91
Segment 3	> 20	6.65

Pre-Retirement - Mortality Table - None

Turnover/Disability - None
Salary Scale - None
Expense Load - None
Ancillary Ben Load - None

Post-Retirement - Mortality Table - 16C - 2016 Combined - IRC 430(h)(3)(A)

Cost of Living - None

Asset Valuation Method: Fair market value of assets adjusted for contributions under IRC 430(g)(4)

#### **Discrimination Test Assumptions:**

HCE Determination - Based on all employees

Otherwise Excludable - Otherwise Excludable HCEs are included with the Not Otherwise Excludable employees

#### 410(b)/401(a)(4) Testing:

Pre-Retirement - Interest - 8.5%

Post-Retirement - Interest - 8.5%

Mortality Table - U84 - 1984 Unisex

Permissively Aggregated Plans - Tested as a Single Plan

Compensation - Use current compensation to calculate the benefit accrual rate (annual method)

Testing Age - Normal retirement age or attained age, if older

Testing Service - Separate benefiting service for DC and for DB for Accrued-to-Date Method

Normal Form for MVAR - Joint with 50% Survivor Benefits

#### 401(a)(26) Testing:

Compensation - Use current compensation to calculate the benefit accrual rate for 401(a)(26)

Testing Age - Normal retirement age or attained age, if older

# Schedule SB, line 19 - Discounted Employer Contributions

## Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003

For the plan year 01/01/2016 through 12/31/2016 Valuation Date: 01/01/2016

	Date	Amount	Adjusted Contribution	Adjusted Prior Year Contribution	Adjusted Quarterly	Effective Rate	Penalty Rate
Deposited Contribution	05/23/2017	\$70,000					
Applied to Additional Contribution	01/01/2016	3,964	3,653	0	0	6.05	0
Applied to MRC	01/01/2016	66,036	60,862	0	0	6.05	0
Totals for Deposited Contribution		\$70,000	\$64,515	\$0	\$0		

# Schedule SB, line 22 - Description of Weighted Average Retirement Age

### Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003 For the plan year 01/01/2016 through 12/31/2016

The age reported is the weighted average of the assumed retirement ages for all active participants as of the valuation date based on their funding target or target normal cost should the funding target of the plan be zero rounded to the nearest whole age. For an active late retiree, the assumed retirement age may be later than the Plan's normal retirement age. Each participant's rate of retirement is assumed to be 100% of his/her assumed retirement age.

# **Schedule SB, line 32 - Schedule of Amortization Bases**

## Woodstock Physical Therapy Defined Benefit Pension Plan 20-3678810 / 003

## For the plan year 01/01/2016 through 12/31/2016

	Date Base Established	Original Base Amount	Type of Base	Present Value of Remaining Installments	Years Remaining Amortization Period	Amortization Installment
	01/01/2016	5,378	Shortfall	5,378	7	889
Totals:				\$5,378		\$889