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| Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500. | OMB Nos. 1210-0110 1210-0089 2016 This Form is Open to Public Inspection |
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| Part I | Annual Report Identification Information | | |
| For calendar plan year 2016 or fiscal plan year beginning <u>02/01/2016</u> and ending <u>01/31/2017</u> | | | |
| A | This return/report is for: | <input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) | |
| | <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ | | |
| B | This return/report is: | <input 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) | | |
| C | If the plan is a collectively-bargained plan, check here. <input type="checkbox"/> | | |
| D | Check box if filing under: | <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program | |
| | <input type="checkbox"/> special extension (enter description) | | |

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| Part II | Basic Plan Information —enter all requested information | | |
| 1a | Name of plan <u>F. THEMISTOCLE, MD, PC RETIREMENT PLAN AND TRUST</u> | 1b | Three-digit plan number (PN) ► <u>001</u> |
| | | 1c | Effective date of plan <u>02/01/2011</u> |
| 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) <u>F. THEMISTOCLE, MD, PC</u> <u>C/O COLEMAN CONSULTING CORP.</u> <u>PO BOX 220</u> <u>JERICHO, NY 11753</u> | 2b | Employer Identification Number (EIN) <u>90-0198011</u> |
| | | 2c | Plan Sponsor's telephone number <u>212-629-8940</u> |
| | | 2d | Business code (see instructions) <u>812990</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 accompanying schedules, statements and attachments, 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.

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| SIGN HERE | Filed with authorized/valid electronic signature. | 10/31/2017 | FENAR THEMISTOCLE |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 10/31/2017 | FENAR THEMISTOCLE |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |
| Preparer's name (including firm name, if applicable) and address (include room or suite number) | | | Preparer's telephone number |
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For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div> |
| 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 | 4b EIN 4c PN |
| 5 Total number of participants at the beginning of the plan year | 5 2 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year..... a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested | <div style="background-color: #cccccc; height: 20px; width: 100%;"></div> 6a(1) 2 6a(2) 3 6b 1 6c 0 6d 4 6e 0 6f 4 6g 0 6h 0 |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)..... | 7 |
| 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 1A 3D b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: | |
| 9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | 9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor |
| 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) | |
| a Pension Schedules (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input checked="" type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input checked="" type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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| 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 |
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For calendar plan year 2016 or fiscal plan year beginning 02/01/2016 and ending 01/31/2017

▶ **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.

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| A Name of plan <u>F. THEMISTOCLE, MD, PC RETIREMENT PLAN AND TRUST</u> | B Three-digit plan number (PN) ▶ <u>001</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>F. THEMISTOCLE, MD, PC</u> | D Employer Identification Number (EIN) <u>90-0198011</u> |
| E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500 |

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| Part I | Basic Information |
| 1 Enter the valuation date: Month <u>01</u> Day <u>31</u> Year <u>2017</u> | |
| 2 Assets: | |
| a Market value | 2a <u>1182964</u> |
| b Actuarial value | 2b <u>1182964</u> |
| 3 Funding target/participant count breakdown | |
| a For retired participants and beneficiaries receiving payment | (1) Number of participants <u>0</u> (2) Vested Funding Target <u>0</u> (3) Total Funding Target <u>0</u> |
| b For terminated vested participants | <u>1</u> <u>1514</u> <u>1514</u> |
| c For active participants | <u>3</u> <u>1236013</u> <u>1236013</u> |
| d Total | <u>4</u> <u>1237527</u> <u>1237527</u> |
| 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 | 4a |
| 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 | 4b |
| 5 Effective interest rate | 5 <u>4.73 %</u> |
| 6 Target normal cost | 6 <u>216662</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.

| | | |
|----------------------------------------------|-------------------------------|----------------------------------------|
| SIGN HERE | | <u>07/06/2017</u> |
| | Signature of actuary | Date |
| <u>CYRIL J. COLEMAN</u> | Type or print name of actuary | <u>14-02302</u> |
| <u>SAME</u> | Firm name | Most recent enrollment number |
| <u>PO BOX 220</u> <u>JERICO, NY 11753</u> | Address of the firm | <u>212-629-8940</u> |
| | | Telephone number (including area code) |

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, see the Instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2016
v. 160205

| 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) | 29409 | 29438 |
| 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) | 29409 | 29438 |
| 10 | Interest on line 9 using prior year's actual return of 1.01% | 29 | 297 |
| 11 | Prior year's excess contributions to be added to prefunding balance: | | |
| a | Present value of excess contributions (line 38a from prior year) | | 3685 |
| 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 1.01% | | 37 |
| 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 | | 3722 |
| d | Portion of (c) to be added to prefunding balance | | 3722 |
| 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) | 29438 | 33457 |

| Part III Funding Percentages | | | |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------|
| 14 | Funding target attainment percentage | 14 | 95.59% |
| 15 | Adjusted funding target attainment percentage | 15 | 100.12% |
| 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 | 95.56% |
| 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 |
| 05/25/2016 | 10037 | 0 | | | |
| 07/13/2016 | 50000 | 0 | | | |
| 08/12/2016 | 25000 | 0 | | | |
| 09/15/2016 | 25000 | 0 | | | |
| 10/14/2016 | 25000 | 0 | | | |
| 03/08/2017 | 85282 | 0 | | | |
| Totals ► | | | 18(b) | 220319 | 18(c) 0 |

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| 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 |
| b | Contributions made to avoid restrictions adjusted to valuation date | 19b |
| c | Contributions allocated toward minimum required contribution for current year adjusted to valuation date | 19c 220319 |
| 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 |
| | | | |

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| Part V | Assumptions Used to Determine Funding Target and Target Normal Cost | | |
| 21 | Discount rate: | | |
| a | Segment rates: | <div style="display: flex; justify-content: space-around;"> <div>1st segment: 4.43%</div> <div>2nd segment: 5.91%</div> <div>3rd segment: 6.65%</div> </div> | <input type="checkbox"/> N/A, full yield curve used |
| b | Applicable month (enter code) | 21b | |
| 22 | Weighted average retirement age | 22 | 62 |
| 23 | Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute | | |
| Part VI | Miscellaneous Items | | |
| 24 | 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 | | |
| 25 | 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 | | |
| 26 | 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 | | |
| 27 | If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment. | 27 | |
| Part VII | Reconciliation of Unpaid Minimum Required Contributions For Prior Years | | |
| 28 | 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 | |
| 30 | Remaining amount of unpaid minimum required contributions (line 28 minus line 29) | 30 | 0 |
| Part VIII | Minimum Required Contribution For Current Year | | |
| 31 | Target normal cost and excess assets (see instructions): | | |
| a | Target normal cost (line 6) | 31a | 216662 |
| b | Excess assets, if applicable, but not greater than line 31a | 31b | 0 |
| 32 | Amortization installments: | Outstanding Balance | Installment |
| a | Net shortfall amortization installment | 0 | 0 |
| 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 (Month _____ Day _____ Year _____) and the waived amount | 33 | 0 |
| 34 | Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) | 34 | 216662 |
| | Carryover balance | Prefunding balance | Total balance |
| 35 | Balances elected for use to offset funding requirement | | 0 |
| 36 | Additional cash requirement (line 34 minus line 35) | 36 | 216662 |
| 37 | Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) | 37 | 220319 |
| 38 | Present value of excess contributions for current year (see instructions) | | |
| a | Total (excess, if any, of line 37 over line 36) | 38a | 3657 |
| 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 | Unpaid minimum required contributions for all years | 40 | 0 |
| Part IX | Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions) | | |
| 41 | If an election was made to use PRA 2010 funding relief for this plan: | | |
| a | Schedule elected | <input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years | |
| 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 | |
| 42 | Amount of acceleration adjustment | 42 | 0 |
| 43 | Excess installment acceleration amount to be carried over to future plan years | 43 | 0 |

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| SCHEDULE I (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Financial Information—Small Plan This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500. | OMB No. 1210-0110 |
| | | 2016 |
| | | This Form is Open to Public Inspection |

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| For calendar plan year 2016 or fiscal plan year beginning 02/01/2016 and ending 01/31/2017 | |
| A Name of plan F. THEMISTOCLE, MD, PC RETIREMENT PLAN AND TRUST | B Three-digit plan number (PN) ► 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 F. THEMISTOCLE, MD, PC | D Employer Identification Number (EIN) 90-0198011 |

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

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| Part I | Small Plan Financial Information |
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Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

| 1 Plan Assets and Liabilities: | | (a) Beginning of Year | (b) End of Year |
|------------------------------------------------------------------------------------|--------------|------------------------------|------------------------|
| a Total plan assets | 1a | 809645 | 1182964 |
| b Total plan liabilities | 1b | 0 | 0 |
| c Net plan assets (subtract line 1b from line 1a) | 1c | 809645 | 1182964 |
| 2 Income, Expenses, and Transfers for this Plan Year: | | (a) Amount | (b) Total |
| a Contributions received or receivable: | | | |
| (1) Employers..... | 2a(1) | 220319 | |
| (2) Participants..... | 2a(2) | 0 | |
| (3) Others (including rollovers) | 2a(3) | 0 | |
| b Noncash contributions | 2b | 0 | |
| c Other income..... | 2c | 154514 | |
| d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) | 2d | | 374833 |
| e Benefits paid (including direct rollovers) | 2e | 1514 | |
| f Corrective distributions (see instructions) | 2f | 0 | |
| g Certain deemed distributions of participant loans (see instructions)..... | 2g | 0 | |
| h Administrative service providers (salaries, fees, and commissions) | 2h | 0 | |
| i Other expenses | 2i | 0 | |
| j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)..... | 2j | | 1514 |
| k Net income (loss) (subtract line 2j from line 2d) | 2k | | 373319 |
| l Transfers to (from) the plan (see instructions) | 2l | | 0 |

| | | | | |
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| 3 Specific Assets: If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions. | | Yes | No | Amount |
| a Partnership/joint venture interests | 3a | | X | |
| b Employer real property | 3b | | X | |
| c Real estate (other than employer real property) | 3c | | X | |
| d Employer securities | 3d | | X | |
| e Participant loans | 3e | | X | |
| f Loans (other than to participants) | 3f | | X | |
| g Tangible personal property | 3g | | X | |

Part II Compliance Questions

| 4 During the plan year: | | Yes | No | Amount |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| a | Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) | | X | |
| b | Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance. | | X | |
| c | Were any leases to which the plan was a party in default or classified during the year as uncollectible? | | X | |
| d | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) | | X | |
| e | Was the plan covered by a fidelity bond? | | X | |
| f | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | X | |
| g | Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| h | Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| i | Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest? | | X | |
| j | Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | | X | |
| k | Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.) | X | | |
| l | Has the plan failed to provide any benefit when due under the plan? | | X | |
| m | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | X | |
| n | If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 | | X | |
| o | 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 service? | | X | |

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ Yes ☒ No Amount:**5b** 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.)

| 5b(1) Name of plan(s) | 5b(2) EIN(s) | 5b(3) PN(s) |
|-----------------------|--------------|-------------|
| | | |
| | | |
| | | |

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? ☐ Yes ☒ No ☐ Not determined.

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year..... (See instructions.)

Part III Trust Information**6a** Name of trust**6b** Trust's EIN**6c** Name of trustee or custodian**6d** Trustee's or custodian telephone number

| | | |
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| SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | OMB No. 1210-0110 2016 This Form is Open to Public Inspection. |
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For calendar plan year 2016 or fiscal plan year beginning 02/01/2016 and ending 01/31/2017

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| A Name of plan <u>F. THEMISTOCLE, MD, PC RETIREMENT PLAN AND TRUST</u> | B Three-digit plan number (PN) ▶ <u>001</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>F. THEMISTOCLE, MD, PC</u> | D Employer Identification Number (EIN) <u>90-0198011</u> |

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| Part I | Distributions |
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All references to distributions relate only to payments of benefits during the plan year.

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| 1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions | 1 | <u>0</u> |
| 2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): _____ | | |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3. | | |
| 3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year | 3 | <u>0</u> |

| | |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.) |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------|-----------------------------------------|
| 4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8. | | | |
| 5 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 ruling letter granting the waiver. Date: Month _____ Day _____ Year _____ If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. | | | |
| 6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) | 6a | | |
| b Enter the amount contributed by the employer to the plan for this plan year | 6b | | |
| c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) | 6c | | |
| If you completed line 6c, skip lines 8 and 9. | | | |
| 7 Will the minimum funding amount reported on line 6c be met by the funding deadline? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input checked="" type="checkbox"/> N/A |

| | |
|-----------------|-------------------|
| Part III | Amendments |
|-----------------|-------------------|

| | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------------|
| 9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input checked="" type="checkbox"/> No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------------|

| | |
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| Part IV | ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11 a Does the ESOP hold any preferred stock? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12 Does the ESOP hold any stock that is not readily tradable on an established securities market? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule R (Form 5500) 2016
v. 160205

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

| | | | |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| 14 | Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for: | | |
| | a The current year | 14a | |
| | b The plan year immediately preceding the current plan year | 14b | |
| | c The second preceding plan year | 14c | |
| 15 | Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to: | | |
| | a The corresponding number for the plan year immediately preceding the current plan year | 15a | |
| | b The corresponding number for the second preceding plan year | 15b | |
| 16 | Information with respect to any employers who withdrew from the plan during the preceding plan year: | | |
| | a Enter the number of employers who withdrew during the preceding plan year | 16a | |
| | b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers | 16b | |
| 17 | If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. <input type="checkbox"/> | | |

| | |
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| Part VI | Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans |
|----------------|---------------------------------------------------------------------------------------------------|

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|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 18 | If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment |
| 19 | If the total number of participants is 1,000 or more, complete lines (a) through (c) a Enter the percentage of plan assets held as: Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____% b Provide the average duration of the combined investment-grade and high-yield debt: <input type="checkbox"/> 0-3 years <input type="checkbox"/> 3-6 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 9-12 years <input type="checkbox"/> 12-15 years <input type="checkbox"/> 15-18 years <input type="checkbox"/> 18-21 years <input type="checkbox"/> 21 years or more c What duration measure was used to calculate line 19(b)? <input type="checkbox"/> Effective duration <input type="checkbox"/> Macaulay duration <input type="checkbox"/> Modified duration <input type="checkbox"/> Other (specify): _____ |

| | |
|-----------------|---------------------------------|
| Part VII | IRS Compliance Questions |
|-----------------|---------------------------------|

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20a Is the plan a 401(k) plan? If "No," skip b | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply: | <input type="checkbox"/> Design-based safe harbor <input type="checkbox"/> "Prior year" ADP test <input type="checkbox"/> "Current year" ADP test <input type="checkbox"/> N/A |
| 21a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply: | <input type="checkbox"/> Ratio percentage test <input type="checkbox"/> Average benefit test <input type="checkbox"/> N/A |
| 21b 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22a If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter ____/____/____ and the serial number _____. | |
| 22b If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter ____/____/____. | |

SUMMARY – Schedule SB Attachment

This Actuarial Valuation Report covers the plan year mentioned herein..

An Actuarial valuation of the above plan has been completed based on the assumption that financial and employee census data provided by the plan administrator are complete and accurate. It is based on the actuarial funding method, assumptions and other data set forth in this report.

This report contains exhibits of descriptive material concerning plan provisions, funding methods and assumptions, and other pertinent factors underlying the determination of contribution levels and plan liabilities as well as exhibits of the various actuarial computations made in support of the determination of the contributions. An actual copy of IRS Form 5500 Schedule SB is included in this report.

The funding method used for preparation of Schedule SB is the modified unit credit method required by the Pension Protection Act (PPA). Under this funding method, the Target Normal Cost is the present value of all benefits which are expected to accrue or to be earned under the plan during the plan year. Any benefit attributable to services performed in a preceding plan year that is increased by reason of any increase in compensation during the current plan year shall be treated as having accrued during the current plan year for purposes of determining the Target Normal Cost.

If the plan assets are inadequate to cover the present value of the benefits that were already accrued as of the beginning of the plan year (Funding Target) an additional charge called the Shortfall Installment may also be due. The Funding Target includes an allowance for ancillary death benefits provided under life insurance contracts if any such contracts are owned by the plan.

The recommended contribution may be higher than the minimum required under the PPA mandated funding method. The Individual Aggregate Funding Method is used for comparison purposes to generate a more level funding pattern where applicable.

The Enrolled Actuaries for Coleman-Pension.Com meets the Qualification Standards set forth by the Joint Board for the Enrollment of Actuaries c/o Department of Treasury and Labor pursuant to the Employee Retirement Income Security Act, (ERISA). They are qualified to render the actuarial opinion contained herein.

ASSUMPTIONS - Schedule SB Attachment

FUNDING ASSUMPTIONS -

Cost Method : Unit Credit

Pre Retirement : Interest @ 5 % per annum
Salary Scale - None assumed
Withdrawal Rates - None assumed

Mortality Table : Male : None assumed
Female: None assumed

Post Retirement : Interest @ 5 % per annum
Cost of Living Adjustment - None assumed
Loading For Expenses - None assumed

Mortality Table : Male : 83 IAM
Female: 83 IAM

PV OF AB ASSUMPTIONS

Pre Retirement : Interest @ 5 % per annum
Withdrawal Rates - None assumed

Mortality Table : Male : None assumed
Female: None assumed

Post Retirement : Interest @ 5 % per annum
Loading For Expenses - None assumed

Mortality Table : Male : 83 IAM
Female: 83 IAM

**SCHEDULE SB
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment 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**

For calendar plan year 2016 or fiscal plan year beginning 02/01/2016 and ending 01/31/2017

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.

A Name of plan

F. THEMISTOCLE, MD, PC RETIREMENT PLAN AND TRUST

B Three-digit
plan number (PN)

001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF

F. THEMISTOCLE, MD, PC

D Employer Identification Number (EIN)

90-0198011

E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B**F** Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500**Part I Basic Information**

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|--------------------------|
| 1 Enter the valuation date: Month <u>01</u> Day <u>31</u> Year <u>2017</u> | | | |
| 2 Assets: | | | |
| a Market value | | 2a | 1182964 |
| b Actuarial value | | 2b | 1182964 |
| 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 | 1 | 1514 | 1514 |
| c For active participants | 3 | 1236013 | 1236013 |
| d Total | 4 | 1237527 | 1237527 |
| 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 | | 4a | |
| 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 | | 4b | |
| 5 Effective interest rate | 5 | | 4.73% |
| 6 Target normal cost | 6 | | 216662 |

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.

**SIGN
HERE***SIGNATURE OF FIVE*

Signature of actuary

07/06/2017

Date

CYRIL J. COLEMAN

Type or print name of actuary

14-02302

Most recent enrollment number

SAME

Firm name

212-629-8940

Telephone number (including area code)

PO BOX 220
JERICHO, NY 11753

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, see the Instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2016
v. 160205

**Application for Extension of Time
To File Certain Employee Plan Returns**

OMB No. 1545-0212

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.
► Information about Form 5558 and its instructions is at www.irs.gov/form5558

File With IRS Only**Part I Identification**

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------|-----------|-------------|
| A Name of filer, plan administrator, or plan sponsor (see instructions) F THEMISTOCLE MD Number, street, and room or suite no. (If a P.O. box, see instructions) PO BOX 220 City or town, state, and ZIP code JERICHO NY 11753 | B Filer's identifying number (see instructions) Employer identification number (EIN) (9 digits XX-XXXXXXX) 90-0198011 Social security number (SSN) (9 digits XXX-XX-XXXX) | | | | |
| | C Plan name F THEMISTOCLE PENSION PLAN | Plan number 0 0 1 | Plan year ending— MM DD YYYY | | |
| | | | 1 | 31 | 2017 |

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

- 1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, C above.
- 2 I request an extension of time until 1 1 / 1 5 / 2 0 1 7 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until ____ / ____ / ____ to file Form 8955-SSA (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is **automatically approved** to the date shown on line 2 and/or line 3 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 (see instructions)

- 4 I request an extension of time until ____ / ____ / ____ to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax ► **a**

b Enter the payment amount attached ► **b**

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date ► **c**

- 5 **State in detail why you need the extension:**

DATA NOT RECEIVED FROM FUNDING AGENT.

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ►

Date ►