	Form 5500-SF Short Form Annual Return/Report of Small Emp Benefit Plan				oyee	OMB Nos. 1210-0110 1210-0089				
	Internal Revenue Service This form is required to be filed under sections 104 and 4065 of the Employee						2017			
	epartment of Labor enefits Security Administration						This Form is Open to Public Inspection			
Pension Be	enefit Guaranty Corporation	Complete all entries in a		nce with the instru	uctions to the Form 5	500-SF.	Public Inspection			
Part I		Identification Information								
For calenda	ar plan year 2017 or fis	cal plan year beginning 01/01/2				2/31/2017				
A This ret	turn/report is for:	a single-employer plan	list	of participating em			king this box must attach a vith the form instructions.)			
<b>B</b> This rote	urn/report is	a one-participant plan		reign plan						
		the first return/report		final return/report						
		an amended return/report	a sh	ort plan year return	/report (less than 12 m	onths)				
C Check	box if filing under:	X Form 5558	auto	omatic extension		DFVC p	program			
		special extension (enter descr	ription)							
Part II	Basic Plan Info	rmation—enter all requested inf	formatior	<u></u>						
1a Name	of plan					1b Thre				
SADASHIV S	S. SHENOY, M. D. , PL	LC DEFINED BENEFIT PENSION	N PLAN			plan (PN)	number 001			
						( )	ctive date of plan			
							01/01/2007			
		ver, if for a single-employer plan) n, apt., suite no. and street, or P.O	D. Box)			2b Employer Identification Number (EIN) 26-4711666				
City or		e, country, and ZIP or foreign posta		if foreign, see instru	uctions)		nsor's telephone number			
						716-631-8736 2d Business code (see instructions)				
78 BROWNS	STONE COURT					,				
E. AMHERS						621111				
0										
Ja Plan a	dministrator's name an	d address X Same as Plan Spor	nsor.			<b>3b</b> Administrator's EIN				
						<b>3c</b> Administrator's telephone number				
		plan sponsor or the plan name ha				4b EIN				
•	an, enter the plan spor or's name	nsor's name, EIN, the plan name a	and the p	lan number from th	e last return/report.	<b>4d</b> PN				
C Plan N										
5a Totol -	number of participants	at the beginning of the plan year				5a	5			
		at the end of the plan year				5b	0			
C Numb	er of participants with a	account balances as of the end of	the plan	year (only defined	contribution plans	5c				
•	,	ticipants at the beginning of the pla				5d(1)	5			
		rticipants at the end of the plan yea				5d(2)	0			
e Number of participants who terminated employment during the plan year with accrued benefits that were less					5e	0				
than Caution: A	penalty for the late of	or incomplete filing of this return	n/report	will be assessed i	unless reasonable cau		blished.			
Under pena SB or Sche	alties of perjury and oth edule MB completed ar	ner penalties set forth in the instruc nd signed by an enrolled actuary, a	ctions, I c	declare that I have	examined this return/re	port, includi	ing, if applicable, a Schedule			
	true, correct, and comp			10/10/2019						
SIGN HERE		valid electronic signature.		10/10/2018	SADASHIV S. SHENC		oo nlon oderinisteeter			
SIGN	Signature of plan a	uninistrator		Date	Enter name of individ	uai signing	as plan administrator			
SIGN HERE	Cignotine of any	ver/alon one		Data	Enter name of the ball					
	Signature of employ	yer/pian sponsor		Date	Enter name of individ	uai signing	as employer or plan sponsor			

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

Form 5500-SF (2017) v.170203

	Were all of the plan's assets during the plan year invested in eligib							X Yes 🗌 N	lo	
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							X Yes N	lo	
	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							Not determined	t	
	If "Yes" is checked, enter the My PAA confirmation number from th	e PBGC p	remium filing for this p	an yea	r			. (See instructions.	)	
Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End	of Year		
а	Total plan assets	7a		61177			(,	0		
b	Total plan liabilities	7b								
С	Net plan assets (subtract line 7b from line 7a)	7c	14(	61177				0		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) <sup>-</sup>	Γotal		
а	Contributions received or receivable from: (1) Employers	. 8a(1)								
	(2) Participants	8a(2)								
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b		11576						
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						11576		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	14	1472753						
е	Certain deemed and/or corrective distributions (see instructions)	8e								
f	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses									
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						1472753		
i	Net income (loss) (subtract line 8h from line 8c)	8i					-1461177			
j	Transfers to (from) the plan (see instructions)	8j								
Pa	rt IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 1A $3B$ $3D$ 1I	feature co	odes from the List of Pla	an Chai	racteri	stic Co	des in the ins	tructions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	cterist	ic Cod	es in the instr	uctions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Amount		
а	Was there a failure to transmit to the plan any participant contribut described in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	iduciary Correction	10		V				
h	Program)			10a		Х				
	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)					Х				
С	Was the plan covered by a fidelity bond?			10c	X			500000		
d	<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?					x				
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.).					x				
f				10f		Х				
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of vear-	end.)	10g		Х				
	If this is an individual account plan, was there a blackout period?			10g		×				

 r

Г

Page 3- 1

Part	VI Pen	sion Funding Compliance				
11		fined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sche D) and line 11a below)	edule S	ŝВ	י 🗌	res 🗙 No
11a	Enter the	Inpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a			
12	ERISA?	efined contribution plan subject to the minimum funding requirements of section 412 of the Code or section complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	302 o	f	י []	∕es Ⅹ No
a		of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and e waiver			f the lette _ Year _	r ruling
lf y	ou comple	ted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				
b	Enter the m	inimum required contribution for this plan year	12b			
С	Enter the a	nount contributed by the employer to the plan for this plan year	12c			
d		e amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a mount)	12d			
е	Will the mi	nimum funding amount reported on line 12d be met by the funding deadline?		Yes	No	N/A
Part '	VII Plai	Terminations and Transfers of Assets				
13a	Has a reso	ution to terminate the plan been adopted in any plan year?		X Yes	N	0
	lf "Yes," e	ter the amount of any plan assets that reverted to the employer this year	13a			C
b		e plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the he PBGC?			Yes	No
С	, 0	his plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) ats or liabilities were transferred. (See instructions.)	to			
1	3c(1) Nam	e of plan(s): 13c(2)	EIN(s)		13c(3	<b>)</b> PN(s)

To: 18185932036 From: 17165683600

Date: 10/11/18 Time: 5:18 AM Page: 04

Oct/11/2018 8:18:40 AM	KALE	EIDA HEALTH 715568			-	4/6		
Form 5500-SF	Short Form Annu	ual Return/Report Benefit Plan	t of Small Empl	oyee	OM	B Nos. 1210-0110 1210-0086		
Department of the Treasury Internal Revenue Service	This form is required to be fil	This form is required to be filed under sections 104 and 4065 of the Employee						
Department of Labor Employee Benefits Security Administratio	<u>n</u>	Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of th Revenue Code (the Code).						
Pension Benefit Guaranty Corporation	Complete as entries in	accordance with the inst	ructione to the Form 5	500-SF.		Inspection		
Part I Annual Report	rt Identification Information		and ending	107	31/2017	<u>- 3</u> 		
or calendar plan year 2017 or	_	01/01/2017						
A This return/report is for:	🔀 a single-employer plan		nployer information in a					
B This return/report is								
э таатацаттерогла	the first return/report	X the final return/report						
	an amended return/report	a short plan year retur	n/report (less than 12 m	ionths)				
C Check box if filing under:	X Form 5558	automatic extension		DFVC pr	ooram	2000 2000		
<b>-</b>	Special extension (enter desc				-0			
						<u>8</u> 5/		
	formation—enter all requested in	iromation		15 Three	-dialt	<u></u>		
18 Name of plan		d Damafit			number	1995 (1995) 1995		
-	, M. D. , PLLC Define	a penerre		(PN)		001		
Pension Plan					tive date of pl 01/2007	lan		
a Pian sponsor's name (emp	loyer, if for a single-employer plan)			2b Emple	oyer.Identifica	tion Number		
Mailing address (include ro	iom, apt., suite no. and street, or P.	O. Box) tal ando (Mercian, can inst	n (stione)	(EIN)	26-47116	66		
Sadashiv S. Shenoy	nce, country, and ZIP or foreign pos	aar code (moreign, see mar	ruouuriay	2c Sponsor's telephone number				
Sadability D. Shenoy	,, 1990			-	6)631-87			
				2di Busin	ess code (se	e instructions)		
78 Brownstone Cour	t					8		
E. Amherst		NY	14051	621	111			
	and eddress 🔀 Same as Plan Spo				nistrator's El	J		
						Ś.		
				3c Admir	histrator's tele	sphone numbe		
4 If the name and/or EIN of t	he plan sponsor or the plan name h	as changed since the last r	etum/report filed for	4b EIN				
this plan, enter the plan sp	consor's name, EIN, the plan name	and the plan number from t	he last return/report.	4-2				
a Sponsor's name				4d PN		×.		
C Plan Name								
				5a		<u>*</u>		
	ts at the beginning of the plan year.			<b></b>		<u></u>		
<b>b</b> Total number of participan	ts at the end of the plan year			5b		3		
C Number of participants with	h account balances as of the end of	the plan year (only defined	i contribution plans	5C				
				5d(1)				
d(1) Total number of active participants at the beginning of the plan year				5d(2)		3		
d(2) Total number of active participants at the end of the plan year								
9 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested								
Caution: A penalty for the lat	e or incomplete filing of this retui	n/report will be assessed	uniess reasonable ca	use is estab	lished.	ý,		
Inder penalties of perjury and BB or Schedule MB completed	other penalties set forth in the instru- and signed by an enrolled actuary,	ctions, i declare that I have as well as the electronic ve	examined this return/re rsion of this return/repoi	t, and to the	ng, if applicab	le, a Schedule nowledge and		
elief, it is true, correct, and co	Junn	Ididia	SADASHIV S. SI	HENOY		9		
HERE	vounne					<u>.</u> . //		
Signature of plan	administrator	Date	Enter name of individ	ual signing a	as plan admin	hatrator S		
BIGN	1 Shuns	10/10/18				4		
HERE	toyer/plan sponsor	Date	Enter name of individ	ual stoning s	as employer o	piplan sponsor		

HERE Signature of employer/plan aponeor For Paperwork Reduction Act Notice, see the instructions for Form 5500-SF.

Oct/11/2018 8:18:40 AM

To: 18185932036 From: 17165683600 Date: 10/11/18 Time: 5:18 AM Page: 05 KALEIDA HEALTH 7155686447

5/6

	Form 5500-SF 2017		Page 2		<b></b>	. <b></b> i				
b	Were all of the plan's assets during the plan year invested in eligit Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See Instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan can	an Indepa and condi tot use Fo	ndent qualified public a tions.) orm 5500-SF and mus	accoun It inste	tant (l ad us	QPA) e Forr	n 5500.	<u>X</u>	Yes Yes	No
C	If the plan is a defined benefit plan, is it covered under the PBGC it If "Yes" is checked, enter the My PAA confirmation number from the					?, [ 	]Yes XN		1320	ermined ictions.)
Pa	ntilli Financial Information								3	
7	Plan Assets and Liabilities		(a) Beginning	of Yea	r		(b) E	nd of Ye	<u>ar</u>	
a	Total plan assets	7 <u>a</u>	1,	461,	177					
b	Total plan llabilities	7b							14.24	
<u> </u>	Net plan assets (subtract line 7b from line 7a)	70	1,	461,	177				3	(
8	Income, Expenses, and Transfers for this Plan Year	20888	(a) Amour	it.			(1	) Total	3	
а	Contributions received or receivable from:							1000		
	(1) Employers	8a(1)				na an a			181-076-03 18 <b>1</b> -076-03	
	(2) Participants	8a(2)				anterio Second	n de la serie de la serie La serie de la s		AND COLOR OF COLOR OF COLOR OF COLOR OF COLOR OF COLOR OF COL	oranis sintensia Georgeo Second
<u> </u>	(3) Others (including rollovers)	<u>8a(3)</u>		1 1	576	20857.49 8000.58		ere an an an an Tag/ an an an an an	States in the second	RESCHARZERS RESCHARZERS
·	Other income (loss)	80		上上 <b>。</b> 高高的高的	576	HARNING.		99999999999999999999999999999999999999	1990 (1990) 19	
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	80				Alexand		1497-14 <b>9</b> 249336	1. § 1000000000000000000000000000000000000	L1,576
d	Benefite paid (including direct rollovers and insurance premiuma to provide benefits)	84	1,	472,	753					
e	Cartain deemed and/or corrective distributions (see instructions)	80		· · ·					<b>\$</b> 392.5	
f	Administrative service providers (selarles, fees, commissions)	8f								121228)
à	Other expenses	8g								10/00/2020
	Total expenses (add lines 8d, 8e, 8f, and 8g)					1,4			1.47	2,75
	Net income (loss) (subtract line 8h from line 8c)		2			-1,46				
÷	Transfers to (from) the plan (see instructions)	81	alle de la construction de la const La construction de la construction d							
	rt IV Plan Characteristics	្រុក្			<u> </u>	2003.99999999999999999999999999999999999		999-900-9700-960-978 999-900-978	9888399999 3	AMERICANICO S
9a 9a	If the plan provides pension benefits, enter the applicable pension 1A 3B 3D 1I	feature co	des from the List of Pi	an Cha	racter	istic C	odes in the i	nstructio	<b>18</b> :	······
b	If the plan provides welfare benefits, enter the applicable welfare f	eature coo	les from the List of Pla	n Char	acteris	stic Co	des in the In	structions		
Par	tV Compliance Questions	,								
10	During the plan year:				Yes	No		Amou	nit	
8	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	/oluntary F	iduciary Correction	10a		x				
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not	include transactions	10b		x	1			
C	Was the plan covered by a fidelity bond?			10c	x	l.			50	0,000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bo	nd, that was caused	10d		x				<u>.,,,,</u>
e	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	ner person se or all of	s by an insurance the benefits under	10¢		x			la este contra la contra de la co	
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		x			100	
g				10g		x			. 22 19	
-	If this is an individual account plan, was there a blackout period? 2520.101-3.)	(See Instru	uctions and 29 CFR	10 <u>9</u>		x				
i	If 10h was answered "Yes," check the box if you either provided to exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	101						

To: 18185932036 From: 17165683600 Oct/11/2018 8:18:40 AM

Date: 10/11/18 Time: 5:18 AM Page: 06 KALEIDA HEALTH 7155686447

6/6

Yes 🗌 No

0

	Form 5500-SF 2017	Page 3-
Part V	VI Pension Funding Compliance	
11		requirements? (If "Yes," see Instructions and complete Schedule SB
11a	Enter the unpaid minimum required contributions for all	years from Schedule SB (Form 5500) line 40 11a
12	Is this a defined contribution plan subject to the minimu ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and	m funding requirements of section 412 of the Code or section 302 of 12e below, as applicable.)
Ø	If a waiver of the minimum funding standard for a prior y	ear is being amortized in this plan year, see instructions, and enter the d

12	2 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver.	nd enter Da	the date <u>Y</u>	of the I	letter n	uling	•	
H :	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				<u> </u>			
b	Enter the minimum required contribution for this plan year	12b	<u> </u>		<u> </u>		0	
	Enter the amount contributed by the employer to the plan for this plan year	120			0.00		Q	
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	120						
e	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes		<u>্য স</u>	N/A		
Part	VII Plan Terminations and Transfers of Assets				3 5			
13ø	Has a resolution to terminate the plan been adopted in any plan year?	•	X Ya	3	No			
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	. 13e					0	
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under th control of the PBGC?			X Yea	<u> </u>	No		
¢	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan( which assets or liabilities were transferred. (See instructions.)				16.2.2			
		) EIN(s)		1:	3c(3) P	<u>'N(s)</u>		
					den Alberta Stratt			