Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Annual Report Identification Information

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).

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

2017

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection**

For calendar plan year 2017 or fiscal plan year beginning and ending a multiple-employer plan (not multiemployer) (Filers checking this box must attach a a single-employer plan list of participating employer information in accordance with the form instructions.) **A** This return/report is for: a one-participant plan a foreign plan B This return/report is the first return/report the final return/report an amended return/report a short plan year return/report (less than 12 months) C Check box if filing under: DFVC program Form 5558 automatic extension special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan **1b** Three-digit plan number BACK TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 401(K) PLAN (PN) ▶ 001 1c Effective date of plan 01/01/2014 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number Mailing address (include room, apt., suite no. and street, or P.O. Box) 45-3642428 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) **2c** Sponsor's telephone number BACK TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 646-657-0032 2d Business code (see instructions) 333 WEST 52ND ST 541990 NEW YORK, NY 10019 3b Administrator's EIN **3a** Plan administrator's name and address X Same as Plan Sponsor. 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for 4b EIN this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. **4d** PN Sponsor's name C Plan Name 5a 12 5a Total number of participants at the beginning of the plan year 5_b 12 **b** Total number of participants at the end of the plan year..... Number of participants with account balances as of the end of the plan year (only defined contribution plans 12 5c complete this item)..... 5d(1) d(1) Total number of active participants at the beginning of the plan year..... 12 5d(2) 12 d(2) Total number of active participants at the end of the plan year Number of participants who terminated employment during the plan year with accrued benefits that were less \cap 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 Filed with authorized/valid electronic signature 10/11/2018 NANCY SHAPIRO SIGN **HERE** Enter name of individual signing as plan administrator Signature of plan administrator Date

Date

Signature of employer/plan sponsor

SIGN HERE

Enter name of individual signing as employer or plan sponsor

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	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)							X Yes	
С	If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year								ermined uctions.)
Pa	t III Financial Information	1							
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End	of Year	
a	Total plan assets	7a	20	00462				248254	
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7с	20	00462				248254	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) ⁻	Total	
a	Contributions received or receivable from: (1) Employers	8a(1)		8336					
	(2) Participants	8a(2)		6000					
	(3) Others (including rollovers)	8a(3)		4770					
b	Other income (loss)	8b	;	35734					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						54840	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
е	Certain deemed and/or corrective distributions (see instructions)	8e							
f	Administrative service providers (salaries, fees, commissions)	8f		3885					
g	Other expenses	8g		3163					
<u>h</u>	otal expenses (add lines 8d, 8e, 8f, and 8g)							7048	
<u> </u>	Net income (loss) (subtract line 8h from line 8c)	8i						47792	
	Transfers to (from) the plan (see instructions)	8j							
Par	t IV Plan Characteristics								
9a 	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 2T 3D	feature co	des from the List of Plant	an Cha	racteris	stic Co	des in the ins	tructions:	
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	es from the List of Pla	n Chara	acterist	ic Cod	les 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 contributescribed in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	iduciary Correction	100		X			
b	Program) Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not	include transactions	10a 10b		X			
С				10c	X			25	000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		Χ			
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.)			10e	X			4	349
f	Has the plan failed to provide any benefit when due under the plan	n? <u></u>		10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		X			
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	•		10h		X			
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i					
	1 1 0 11								

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Part	VI Pension Funding Compliance				
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sch (Form 5500) and line 11a below)		В	. Y	es No
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 minimum funding requirements of section 412 of the Code or section ERISA?	n 302 of			es X No
а	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	d enter t		of the letter Year	ruling
lf y	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				
b	Enter the minimum required contribution for this plan year	12b			
С	Enter the amount contributed by the employer to the plan for this plan year	12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No	N/A
Part '	VII Plan Terminations and Transfers of Assets				
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes	X No)
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			Yes X	No
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)) to			
1	3c(1) Name of plan(s): 13c(2)	EIN(s)		13c(3)	PN(s)

Form 5500-SF

Department of the Treasury Internal Revenue Service

Short Form Annual Return/Report of Small Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2017

B This return/report is		u 4005 of the Employee Retirement	2017						
- I when the	e Benefits Security Administration	<u>. </u>	Revenue Code (the Co	ide), and 6058(a) of the Internal	This Form is Open to				
Pension	Benefit Guaranty Corporellor	► Complete all entries in	2007 CONTRACTOR NO. 2007 CONTRACTOR STATE OF THE STATE OF		Public Inspection				
	Annual Repor	rt identification informatio	D CONTRACTOR WILLIAM IN	structions to the Form 5000-SF.					
For cale	ndar plan year 2017 or	fiscal plan year beginning		and ending 12/	22 /202 //				
			a multiple employer	plan (not multiemployer) (Fiters chec amployer information in accordance v	31/2017 king this box must attach a with the form instructions.)				
B This re	sturrvreport is		a foreign plan		,				
		<u> </u>	=						
C Chec	k hav if films under	1900	_	·					
	a ser a many check.								
Don't II	Beals Div. L.			4	6 3				
	Basic Plan In	ormation—enter all requested i	nformation		the state of the s				
		OPRACTIC MIDTOWN WEST	. PC 401(K) PLA	(PN)	number 001				
					tive date of plan 1/2014				
Mall	Mailing address (include room, ant. suite no. and street or P.O. How)				oyar Identification Number 45-3642428				
BACK	TO HEALTH CHIE		sor's telephone number						
					657-0032				
333 WE	3 WEST 52ND ST				2d Business code (see instructions) 541990				
NEW YO	RK	NY 10019		1					
3a Plan	administrator's name :	and address X Same as Plan Spo	DASOr,	3b Admi	nistrator's EIN				
		,—,,			INSUADO EN				
		¥.	x	3c Admi	nlatrator's telephone number				
4 If the	name and/or EIN of the	te plan sponsor or the plan name h	nas changed since the last	return/report filed for 4b EIN					
a Spon	The extension and extension (anter description) art II Basic Pian Information—enter all requested information Apacial extension (anter description) art II Basic Pian Information—enter all requested information Name of plan K TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC 401 (K) PLAN Plan appropria name (employer, if for a single-amployer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and 2IP or foreign postal code (if foreign, see instructions) CK TO HEALTH CHIROPRACTIC MIDTOWN WEST, PC WEST 52ND ST V YORK NY LOU19 Plan administrator's name and address Same as Plan Sponsor. If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report filed this plan, anter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report of active province at the end of the plan year. Total number of participants at the beginning of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with account balances as of the end of the plan year. Number of participants with the participants at the beginning of the plan year with accrued benefits that were in than 1005 vested. Total number of active participants at the beginning of the plan year with accrued benefits that were in than 1005 vested. The participants with terminated amployment during the plan year with accrued benefits that were in participants with the last or incomplete filling of this return/report will be assessed unless reasons or participants with account of the plan year. Schedule MB Schedule MB completed and adjenced by an annolled actuary, a								
				4d PN	31.* International				
58 Total	number of particle and	and the freedomina of the	· · · · · · · · · · · · · · · · · · ·		Sec.				
b Total	number of participants	s of the end of the size many year.	·	ба	i;				
C Numi	number of perilipping dec of participants with	actions and of the plan year	**************************************	5b	. 1				
GEITHE	yene ites ((601))			90	1				
0(1) 10	tel number of active pa	articipents at the beginning of the p	lan year	5d(1)	1000				
CO(2) To	tal number of active pa	irticipants at the end of the plan ye	**************************************		1:				
than	oer or participants who 100% vested	terminated employment during the	e plan year with accrued b	enefits that were less So					
					lished.				
SB or Sch	edule MB completed a	nd signed by an enrolled actuary.							
SIGN	XNm 6		X Iolilla	NANCY SHAPIRO					
HERE	Signature of plan e	Kiministrator			n nion administrati				
BIGN HERE				Enter name of individual signing a	s pian administrator				
	Signature of emplo		Date	Enter name of individual signing a	s employer or plan enones-				
Of Pagarw	ork Reduction Act Notic	e; see the Instructions for Form 5600	LUE	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWI	vi piuli aprilau				

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b	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan cann If the plan is a defined benefit plan, is it covered under the PBGC in	an indepe and condit ot use Fo	ndent qualified public ations.)	account it instea	ant (IC	PA) Form	5500.	X Yes No X Yes No
	If "Yes" is checked, enter the My PAA confirmation number from the	ne PBGC p	remium filing for this p	lan yea	r		(9	X Yes No Not determined No Not determined No (See instructions.) No See instructions. No Not determined No Not determined No Not determined No Not determined Not determined
Pa	rt III Financial Information							
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End of	Year
a	Total plan assets	7a		200,	462			248,254
<u>b</u>	Total plan liabilities	7b			_			
C	Net plan assets (subtract line 7b from line 7a)	7c		200,	462			248,254
8	Income, Expenses, and Transfers for this Plan Year		(a) Amour	nt	\rightarrow		(b) Tota	il
a	Contributions received or receivable from: (1) Employers	8a(1)		8,	336			
	(2) Participants	8a(2)			000			
	(3) Others (including rollovers).	8a(3)			770			
_ <u>b</u>	Other income (loss)	8b		35,	734			
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			_			54,840
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d						
e	Certain deemed and/or corrective distributions (see instructions)	8e						
f	Administrative service providers (salaries, fees, commissions)	8f		3,	885			
g	Other expenses	8g		3,	163			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						7,048
i	Net income (loss) (subtract line 8h from line 8c)	8i						47,792
j	Transfers to (from) the plan (see instructions)	8j						
Pai	t IV Plan Characteristics	·/	·					
9a	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 2T 3D	feature co	des from the List of Pl	an Cha	racteri	stic Co	des in the instruc	tions:
b	If the plan provides welfare benefits, enter the applicable welfare fi	eature cod	les from the List of Pla	n Chara	cterist	ic Coc	les in the instructi	ons:
Par	t V Compliance Questions							
10	During the plan year:				Yes	No	Am	ount
a	described in 29 CFR 2510.3-102? (See instructions and DOL's \	oluntary F	iduciary Correction			х		
	Program) Were there any nonexempt transactions with any party-in-interest			10a				
	reported on line 10a.)			10b		Х		
c	Was the plan covered by a fidelity bond?	**********		10c	Х			25,000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		Х		
е	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.)	ne or all of	the benefits under	10e	Х			4,349
f	Has the plan failed to provide any benefit when due under the pla	in?		10f		Х		
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		Х		
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)			10h		Х		
ī	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	10i				

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Part	VI Pension Funding Compliance							_
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sc (Form 5500) and line 11a below)] [Ye	s 📗 I	No
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 minimum funding requirements of section 412 of the Code or section ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					Ye	s 🛭 I	Vо
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, ar granting the waiver	_	er tl Day	ne date	of the le		uling	
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.		_					
b	Enter the minimum required contribution for this plan year	12	ь					
С	Enter the amount contributed by the employer to the plan for this plan year	12	c					_
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)								
e Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No		N/A	
art	VII Plan Terminations and Transfers of Assets							
13a	Has a resolution to terminate the plan been adopted in any plan year?			Yes	X	No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	. 13a						
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	e Yes X No				No		
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)	s) to						
13c(1) Name of plan(s): 13c(2)			(s)		13	(3) F	PN(s)	
								_
								_