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 6047(e), 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

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 12/01/2008 and ending 11/30/2009

A This return/report is for:
- ☐ a multiemployer plan;
- ☐ a multiple-employer plan; or
- ☒ a single-employer plan;
- ☐ a DFE (specify) ____

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 If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558;
- ☐ automatic extension;
- ☐ the DFVC program;
- ☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
NORTHEAST ORTHOPAEDICS, LLP AD&D, DENTAL, LIFE, VISION

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
NORTHEAST OTHOPAEDICS, LLP

DEBRA L PICCOLO

121 EVERETT ROAD, SUITE 100
ALBANY, NY 12205-1447

121 EVERETT ROAD, SUITE 100
ALBANY, NY 12205-1447

2b Employer Identification Number (EIN)
14-1777794

2c Sponsor's telephone number
518-453-0590

2d Business code (see instructions)
621111

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.

SIGN HERE	Filed with authorized/valid electronic signature.	05/03/2010	DEBRA PICCOLO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

NORTHEAST OTHOPAEDICS, LLP
DEBRA L PICCOLO
121 EVERETT ROAD, SUITE 100
ALBANY, NY 12205-1447

3b Administrator's EIN: 14-1777794

3c Administrator's telephone number: 518-453-0590

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**	106
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	112
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	112
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	112
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
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 Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

4B 4D 4E 4L

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] 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)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

GUARDIAN

DEBRA L PICCOLO OPER MGR
NORTHEAST ORTHOPAEDICS
121 EVERETT ROAD STE 100
ALBANY, NY 12205-1447

January 19, 2010

Plan Number : 00296920
Anniversary Date : 12/1/2009

To help you with the preparation of your form 5500 (Annual Return / Report of Employee Benefit Plan ERISA) for filing with the Department of Labor, we are providing the following information.

You are required to transfer the information from this form to the appropriate schedule, forming Part of the 5500 form furnished by the United States Department of Labor. You will also need Guardian's Tax ID (EIN) and NAIC numbers, which are as follows :

EIC : 13-512-3390
NAIC: 64246

A copy of this form should be retained for your records.

Certified to be correct
The Guardian Life Insurance Company of America.

Brent S. McCann

NRO Group Client Administration
Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

1-888-278-4542

GUARDIAN

Name of Plan : **NORTHEAST ORTHOPAEDICS**

Plan Number : **00296920**

Data for Period From : **12/01/2008** To : **11/30/2009**

The approximate number of employees covered at the end of the plan year : 112

Group Insurance coverage(s) included under this Plan :

AD&D	Dental (Alternately funded)	Life	Optional Life	Vision (Insured)

The following figure represents commissions that are to be reported on Schedule A, Line 2, Element (b):

Contract Identification	Name and Address of Recipient of Commissions	Amount
BM16	HOWARD J ELIAS INC 888 SEVENTH AVENUE NEW YORK NY 10106	$31.57
BM577	THE CAPITAL REGION STRATEGIC EMPLOYEE 951 ALBANY SHAKER ROAD LATHAM NY 12110	$7,597.14
	Total Commission Paid	**$7,628.71**

The following figure represents fees that are to be reported on Schedule A, Line 2, Element (c):

Contract Identification	Name of Recipient of Fees	Amount
24710	THE CAPITAL REGION STRATEGIC EMPLOYEE	$2,819.99
	Total Fees Paid	**$2,819.99**

However, the compensation listed above is not charged to your case in calculating new rates.

Premium due and unpaid at the end of plan year	:	**$0.00**
List gross premium for each contract	:	**$52,733.65**