Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

2009

OMB Nos. 1210-0110 1210-0089

This Form is Open to Public Inspection

Part II Annual Report Identification Information 10/10/2099 and ending 12/31/2009	P	Pension Benefit Guaranty Corporation	 Complete all entries in accor 	dance wit	h the instructions to the Form 550	0-SF.			
A This return/report is for: B This return/report is for: G Check box if filing under: G Check box if filing under independent under the under independent under independen									
B This return/report is for: an amended return/report an amended ret	For	calendar plan year 2009 or fise	cal plan year beginning 01/01/200)9	and ending 1	2/31/2	2009		
C Check box if filing under:	Α.	This return/report is for:	employer plan (not multiemployer)	one-participant plan					
C Check box if filing under:	В	This return/report is for:	first return/report	final retur	n/report				
Special extension (enter description) Part Basic Plan Information—enter all requested information 1a Name of plan NiFIRMARY ANESTHESIA ASSOCIATES PROFIT SHARING PLAN 1b Three-digit plan number (PN) 002 1c Effective date of plan 01/01/1987 2b Employer Identification Number (EIN) 1-1888173 2c Plan sponsor's name and address (employer, if for single-employer plan) (FIN) 1-3-1888173 2c Plan sponsor's telephone number 516-409-5500 2d Business code (see instructions) 621111 3b Administrator's name and address (if same as Plan sponsor, enter "Same") 3b Administrator's EIN 1-3-1888173 3c Administrator's EIN 1-3-1888173 3c Administrator's EIN 1-3-1888173 3c Administrator's EIN 1-3-1888173 3c Administrator's Elephone number 516-409-5500 4b EIN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 4b EIN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 4c PN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 4c PN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 4c PN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 5c PN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 5c PN 1-3-1888173 3c Administrator's Elephone number 510-409-5500 4c PN 1-3-1888173 4c PN 1-3			an amended return/report	short plar	year return/report (less than 12 mor	nths)			
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C Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	b	Total number of participants a	at the end of the plan year			5b		7	
complete this item)	С	Total number of participants v	with account balances as of the end o	of the plan v	vear (defined benefit plans do not	0.0			
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Part III Financial Information 7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year 7a 4320089 1919379 b Total plan liabilities 7b C Net plan assets (subtract line 7b from line 7a) 7c 4320089						5c		7	
under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Part III Financial Information 7 Plan Assets and Liabilities a Total plan assets	6a	Were all of the plan's assets	during the plan year invested in eligib	ole assets?	(See instructions.)		X	Yes N	
If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Part III Financial Information 7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year a Total plan assets 7a 4320089 1919379 b Total plan liabilities 7b from line 7a) 7c 4320089 1919379	b						V	1 vaa □ N	
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8 Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total					(a) Amount		(b) Total		
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a Contributions received or receivable from: (1) Employers 8a(1)		`, ',							
(1) Employers									
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Part IV	Plan	Charac	reristics

SIGN HERE

Signature of employer/plan sponsor

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2F 2G 2J 3B

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

art	V Compliance Questions							
0	During the plan year:		Yes	No		Amo	unt	
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X				
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		Х				
С	Was the plan covered by a fidelity bond?							
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X				
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X				
f	Has the plan failed to provide any benefit when due under the plan?							
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X				
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X				
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3							
art	VI Pension Funding Compliance							
1	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor 5500))						Yes	X No
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Cod						Yes	X No
	(If "Yes," complete 12a or 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 instrugranting the waiver.	nth						
	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				
	Enter the amount contributed by the employer to the plan for this plan year			12c				
	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left negative amount)			12d				
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No	0	N/A
art	VII Plan Terminations and Transfers of Assets							
3а	Has a resolution to terminate the plan been adopted during the plan year or any prior year?						Yes	X No
	If "Yes," enter the amount of any plan assets that reverted to the employer this year			13a				
b	Vere all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control f the PBGC?							
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the pla	n(s) to			- 1		
13c(1) Name of plan(s):				c(2) EI	N(s)	1:	3c(3)	PN(s)
aut	on: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonal	ble cau	ıse is	establ	ished.			
B o	r penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this re Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return , it is true, correct, and complete.				<i>-</i> 11			
SIGI	Filed with authorized/valid electronic signature. 07/28/2010 MARK SCHERE	ER						
	ERE Signature of plan administrator Date Enter name of indiv				s plan adr	ninistra	tor	

Date

Enter name of individual signing as employer or plan sponsor