Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

HERE

SIGN HERE

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

					Inspection		
Part I		tification Information					
For caler	ndar plan year 2009 or fiscal p	plan year beginning 01/01/2009		and ending 12/31/20	009		
A This	eturn/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
		a single-employer plan;	a DFE (sp	pecify)			
B This return/report is:		the first return/report; an amended return/report;	<u></u>	eturn/report; an year return/report (less tha	an 12 months).		
C If the plan is a collectively-bargained plan, check here.					▶ □		
D Chec	k box if filing under:	X Form 5558;	automatio	extension;	the DFVC program;		
	-	special extension (enter des	cription)		_		
Part	I Basic Plan Inform	nation—enter all requested informa					
	ne of plan	.L ASSOCIATES, PC 401(K)/PROFI			1b Three-digit plan number (PN) ▶	001	
THE REPORT OF THE BOOK PROCESS OF THE STATE					1c Effective date of plan 01/01/1998		
(Add	sponsor's name and address ress should include room or s EAST EMERGENCY MEDICA	,	olan)		2b Employer Identifica Number (EIN) 14-1797263	ation	
					2c Sponsor's telephone number 518-383-4008		
400 CLIFTON CORPORATE PARK SUITE 479 CLIFTON PARK, NY 12065		SUITE 479	400 CLIFTON CORPORATE PARK SUITE 479 CLIFTON PARK, NY 12065			е	
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 ele	ectronic signature.	08/27/2010	STANLEY W. DOCKY			
HERE	Signature of plan adminis	rator	Date	Enter name of individual sig	ning as plan administrator		

08/27/2010

Date

Date

STANLEY W. DOCKY

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of DFE

Form 5500 (2009) v.092307.1

	Form 5500 (2009)	age 2	
	Plan administrator's name and address (if same as plan sponsor, enter "Same") ORTHEAST EMERGENCY MEDICAL ASSOCIATES, PC		Administrator's EIN 4-1797263
SU	0 CLIFTON CORPORATE PARK IITE 479 IFTON PARK, NY 12065	r	dministrator's telephone number 18-383-4008
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for the plan number from the last return/report:	r this plan, enter the name, EIN and	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year	5	17
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a	, 6b , 6c , and 6d).	·
а	Active participants	6a	C
b	Retired or separated participants receiving benefits	6b	C
С	Other retired or separated participants entitled to future benefits	6c	9
d	Subtotal. Add lines 6a, 6b, and 6c	6d	9
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	C
f	Total. Add lines 6d and 6e	6f	9
g	Number of participants with account balances as of the end of the plan year (only defined complete this item)		9
	Number of participants that terminated employment during the plan year with accrued bene less than 100% vested	6h	C
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer	· · · · · · · · · · · · · · · · · · ·	
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the L $_{ m 2E}$ $_{ m 2G}$ $_{ m 2J}$ $_{ m 3D}$	ist of Plan Characteristic Codes in the	e instructions:

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

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(3)

9a	Plan fund	ing arrangement (check all that apply)	9b	Plan bene	<u>efit</u> a	arrangement (check all that apply)
	(1)	Insurance	((1)		Insurance
	(2)	Code section 412(e)(3) insurance contracts	((2)		Code section 412(e)(3) insurance contracts
	(3)	Trust	((3)	X	Trust
	(4)	General assets of the sponsor	((4)		General assets of the sponsor
10	Check all	applicable boxes in 10a and 10b to indicate which schedules are at	tached	l, and, wh	ere	indicated, enter the number attached. (See instructions)
а	Pension	Schedules	b	General	Sch	nedules
	(1)	R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	X	I (Financial Information – Small Plan)
	_	Purchase Plan Actuarial Information) - signed by the plan		(3)		A (Insurance Information)
		actuary		(4)		C (Service Provider Information)

(5)

(6)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

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

2009

This Form is Open to Public Inspection

Total Solicin					mapeonom
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009		and ending	12/3	1/2009	
A Name of plan NORTHEAST EMERGENCY MEDICAL ASSOCIATES, PC 401(K)/PROFIT SHARING PLAN	В	Three-digit plan number (PN	1))	001
C Plan sponsor's name as shown on line 2a of Form 5500 NORTHEAST EMERGENCY MEDICAL ASSOCIATES, PC	D	Employer Identific 14-1797263	cation	n Numbe	er (EIN)

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.

Part I Small Plan Financial Information

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
а	Total plan assets	. 1a	1449135	1040953
b	Total plan liabilities	. 1b	0	0
С	Net plan assets (subtract line 1b from line 1a)	1c	1449135	1040953
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
а	Contributions received or receivable:			
	(1) Employers	2a(1)	0	
	(2) Participants	. 2a(2)	0	
	(3) Others (including rollovers)	2a(3)	0	
b	Noncash contributions	2b	0	
C	Other income	. 2c	175807	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		175807
е	Benefits paid (including direct rollovers)	. 2e	499031	
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	5993	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		505024
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		-329217
	Transfers to (from) the plan (see instructions)	. 2I		-78965

3 Specific Assets: If the plan held assets at anytime 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.

	<u>.</u>		Yes	No	Amount
а	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	
	Real estate (other than employer real property)			X	
d	Employer securities	3d		X	
	Participant loans			X	

Schedule I (Form 5500) 2009	Page 2- 1
·	·

Schedule I (Form 5500) 2009

			Yes	No		Amount	
3f	Loans (other than to participants)	3f		X			
g	Tangible personal property	3g		X			
			•	•			
Pa	rt II Compliance Questions						
4	During the plan year:		Yes	No		Amount	
а	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.)	4a		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.	4b		X			
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X			
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X			
е	Was the plan covered by a fidelity bond?	4e	Х				10000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		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?	4g		Х			
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?	4h		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?	4i		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?	4j		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.)	4k	X				
ı	Has the plan failed to provide any benefit when due under the plan?	41		X			
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		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	4n					
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	X Ye	es 🗌 N	No A	Amount:		0
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	entify t	he plan	(s) to w	hich assets	or liabilities v	were
	5b(1) Name of plan(s)			5b(2)	EIN(s)	5b	o(3) PN(s)

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 section 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.

2009

OMB No. 1210-0110

This Form is Open to Public Inspection.

_	04/04/0000			40/04/0	000				
For	calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and	endin		12/31/2	009	1			
	Name of plan	В		e-digit					
NOR	RTHEAST EMERGENCY MEDICAL ASSOCIATES, PC 401(K)/PROFIT SHARING PLAN		•	n numbe	er	00	1		
			(PI	۷)	<u> </u>	00			
	Plan sponsor's name as shown on line 2a of Form 5500	D	Emp	loyer Id	entifica	ation Num	ber (Ell	۷)	
NOR	RTHEAST EMERGENCY MEDICAL ASSOCIATES, PC		14	1-179726	63				
Pa	art I Distributions								
All	references to distributions relate only to payments of benefits during the plan year.								
1	Total value of distributions paid in property other than in cash or the forms of property specified in the								
	instructions			1					
2	Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries du	rina th	ne vea	r (if mor	e than	two, ente	er EINs o	of the tw	VO
	payors who paid the greatest dollar amounts of benefits):	3	, , , ,			,			
	EIN(s):14-1807897								
_	Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.				1				
3	Number of participants (living or deceased) whose benefits were distributed in a single sum, during th	•							
_	year			3					
P	art II Funding Information (If the plan is not subject to the minimum funding requirements	of sec	ction o	f 412 of	the Int	ernal Re	venue C	ode or	
	ERISA section 302, skip this Part)			П	Vaa		Na	П.	1/A
4	Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?			Ш	Yes	Ш	No	ן ⊔ י	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: Mor				,		Year _		_
_	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re				hedul	е.			
6	a Enter the minimum required contribution for this plan year			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)			6с					
	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?			П	Yes	П	No		N/A
				Ш				□ .	
8	If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure pro	viding)						
	automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator			П	Yes	П	No	П	N/A
	with the change?			Ш	.00			П.	4 /~
Pa	art 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			٦,,,,,,		Пъ	41-	Пы	
	box(es). If no, check the "No" box	ease		Decre	ease	∐ Вс	tn	No	<u> </u>
Pa	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975	(e)(7)	of the	Interna	l Reve	nue Code	€,		
10	skip this Part.				0		Vac	П	Ne
10	Were unallocated employer securities or proceeds from the sale of unallocated securities used to repr			<u> </u>			Yes		No
11	a Does the ESOP hold any preferred stock?						Yes	Ш	No
	b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a '(See instructions for definition of "book to back" loop.)						Yes	П	No
	(See instructions for definition of "back-to-back" loan.)						Yes	$\frac{\Box}{\Box}$	No
12	Does the ESOP hold any stock that is not readily tradable on an established securities market?								

Pa	rt V		Additional Information for Multiemployer Defined Benefit Pension Plans
13			lowing information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in see instructions. Complete as many entries as needed to report all applicable employers.
	а	Name o	of contributing employer
	b	EIN	C Dollar amount contributed by employer
	d		ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box e instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year
	е	comple (1) C	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):
	а	Name o	of contributing employer
	b	EIN	C Dollar amount contributed by employer
	d	Date co	ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box
	е	comple (1) C	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):
	а	Name o	of contributing employer
	b	EIN	C Dollar amount contributed by employer
	d		ollective bargaining agreement expires (<i>If employer contributes under more than one collective bargaining agreement, check box</i>
	е	comple (1) C	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):
	а	Name o	of contributing employer
	b	EIN	C Dollar amount contributed by employer
	d		ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box
	е	comple (1) C	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):
	а	Name	of contributing employer
	b b	EIN	C Dollar amount contributed by employer
	d	Date co	ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box
	е	comple (1) C	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):
	а	Name o	of contributing employer
	b	EIN	C Dollar amount contributed by employer
	d	Date co	ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box
	е	Contribution Comple	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) ontribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):

Pag	e	3
ı ay		•

14	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of participant for:	the	
	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 ma employer contribution during the current plan year to:	ke an	
	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 item 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, c supplemental information to be included as an attachment.		
Р	art VI Additional Information for Single-Employer and Multiemployer Defined Benef	it Pens	ion Plans
18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see in information to be included as an attachment	struction	is regarding supplemental
19	If the total number of participants is 1,000 or more, complete items (a) through (c)		
	Enter the percentage of plan assets held as: Stock:% Investment-Grade Debt:% High-Yield Debt:% Real Estate:	_% Oth	ner:%
	b Provide the average duration of the combined investment-grade and high-yield debt: 0-3 years 3-6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-2	21 years	21 years or more
	What duration measure was used to calculate item 19(b)?		
	☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):		

5500 Electronic Filing Authorization

Plan Name: Northeast Emergency Medical Associates, PC 401(K)/Profit Sharing Plan

EIN/PN: 14-1797263/001

Plan Year: 01/01/2009 - 12/31/2009

I hereby authorize Anthony S. Asterino, CPA to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan administrator

sign)

8.26.10

(date)

Plan Sponso

(sign)

8.26.10

(date)

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

2009

This Form is Open to Public Inspection

Part I Annual	Report Identification Informatio	n		
For the calendar pla	n year 2009 or fiscal plan year beginning	01/01/2009	and ending 12/31	/2009
A This return/report i	s for: a multiemployer plan;		a multiple-employer p	plan; or
	🛛 a single-employer plan;		a DFE (specify)	
B This return/report is	s: the first return/report; an amended return/report;		the final return/report	; irn/report (less than 12 months).
C If the plan is a colle	ectively-bargained plan, check.here			
D Check box if filing	under: X Form 5558;		automatic extension:	the DFVC program;
D Chook box // ming	special extension (enter desc	cription)		,,
Part II Basic F	Plan Information enter all requeste			
1a Name of plan	mergency Medical Associates, F		haring Plan	1b Three-digit plan number (PN) ▶ 001
				1C Effective date of plan 01/01/1998
· ·	name and address (employer, if for a single-e I include room or suite no.)	mployer plan)		2b Employer Identification Number (EIN)
Northeast E	mergency Medical Associates, F	ec		14-1797263
				2C Sponsor's telephone number
				(518) 383-4008
400 Clifton	Corporate Park			2d Business code (see
Suite 479	Colpolate fulk			instructions)
US CLIFTON	PARK NY 12065			621111
Caution: A penalty fo	or the late or incomplete filing of this retur	n/report will be assesse	d uniess reasonable cause	ls established.
Under penalties of perstatements and attach	jury and other penalties set forth in the instru ments, as well as the electrodic version of thi	ctions, I declare that I have is return/report, and to the	e examined this return/report, best of my knowledge and be	including accompanying schedules, elief, it is true, correct, and complete.
SIGN HERE	by North	8.26.10	STANLEY W. DOCYK,	МО
· · · – · · · – · – · – · – · – · – · –	e ol/plan administrator	Date	Enter name of individual sig	ning as plan administrator
SIGN FXN	by Doeffe	8.26.10	STANLEY W. DOCYK,	МО
	of employer/plan sponsor	Date	Enter name of individual sig	ning as employer or plan sponsor
SIGN HERE				
Signature	of DFE	Date	Enter name of individual sig	ning as DFE

	Form 5500 (2009)			F	Page 2		
3a	Plan administrator's name and address (if same as plan sponsor, enter "Same	ne")				3b	Administrator's EIN
							Administrator's telephone number
						-	
4	If the name and/or EIN of the plan sponsor has changed since the last return/the plan number from the last return/report:	/repor	t filed t	for	this plan, enter the name, Ell	N and	4b EIN
а	Sponsor's name						4c PN
5	Total number of participants at the beginning of the plan year					5	17
6	Number of participants as of the end of the plan year (welfare plans complete						
а	Active participants					6a	0
b	Retired or separated participants receiving benefits					6b	0
C	Other retired or separated participants entitled to future benefits					6c	9
d	Subtotal. Add lines 6a, 6b and 6c					6d	9
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	eive l	enefit	ts		6e	0
f	Total. Add lines 6d and 6e					6f	9
g	Number of participants with account balances as of the end of the plan year (complete this item)	only o	efined	d c	ontribution plans	6 g	9
h	Number of participants that terminated employment during the plan year with a 100% vested					6h	0
7	Enter the total number of employers obligated to contribute to the plan (only m					7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes f	om the	e l	ist of Plan Characteristic Cod	es in t	he instructions:
Ь	2E 2G 2J 3D If the plan provides welfare benefits, enter the applicable welfare feature code	les fro	m the	: Li	st of Plan Characteristic Code	s in th	e instructions:
9a	Plan funding arrangement (check all that apply)	9b	Plan b	en	efit arrangement (check all th	at app	ly)
	(1) Insurance		(1)] ı	Insurance		
	(2) Code section 412(e)(3) insurance contracts		(2)	_	Code section 412(e)(3) insura	nce co	ontracts
	(3) X Trust		(3) X	_	Trust		
10	(4) General assets of the sponsor		(4)		General assets of the sponsor		ttochad (Con instructions)
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at					ınsı a	ilached. (See instructions)
а				ral ¬	Schedules		
	(1) X R (Retirement Plan Information)		(1)	-	H (Financial Inform	•	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2) X	4	I (Financial Informa		•
	Purchase Plan Actuarial Information) - signed by the plan actuary		(3)	\dashv	A (Insurance Inform		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(4)	\dashv	C (Service Provider		
	Information) - signed by the plan actuary		(5) (6)	1	D (DFE/Participatin G (Financial Transa		

Sponsor Location Information

Sponsor name:

Northeast Emergency Medical Associates, PC

Sponsor DBA name: Sponsor care of name:

400 Clifton Corporate Park

Suite 479

US Clifton Park

NY 12065

SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security Administration** Pension Benefit Guaranty Corporation

For calendar plan year 2009 or fiscal plan year beginning

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).

and ending

12/31/2009

► File as an attachment to Form 5500.

01/01/2009

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

Α	Name of plan	E	3 Thre	e-digit		
	Northeast Emergency Medical Associates, PC 401(K)/Profit Sharing Pla		plan	number	▶	001
				7.77		
C	Plan sponsor's name as shown on line 2a of Form 5500	E) Emp	lover ider	ntificati	on Number (EIN)
	Northeast Emergency Medical Associates, PC			179726:		` '
Comi	plete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. Yo	u mav	/ also c	omplete S	Schedu	lle Lif you are filing as a
	plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large					
P	art I Small Plan Financial Information					
asset benef	ort below the current value of assets and liabilities, income, expenses, transfers and changes in net assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantit at a future date. Include all income and expenses of the plan including any trust(s) or separately matance carriers. Round off amounts to the nearest dollar.	ntees	during (his plan y	ear to	pay a specific dollar
1	Plan Assets and Liabilities: (a) Begi	nning	of Yea	r	(b)	End of Year
а	Total plan assets			9,135		1,040,953
_	Total plan liabilities			0		0
С	Net plan assets (subtract line 1b from line 1a)		1,44	9,135		1,040,953
2		moun				(b) Total
а	Contributions received or receivable	,				Allud
	(1) Employers			0	15	is Astropy in production production is not the office of the control of the other
	(2) Participants			0	! **** ** ***	
	(3) Others (including rollovers)			0	1.2	
b	Noncash contributions			0		
С	Other income		17	5,807		
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) 2d					175,807
е	Benefits paid (including direct rollovers)		49	9,031	,	
f	Corrective distributions (see instructions) 2f			0	-	
g	Certain deemed distributions of participant loans				:	
Ū	(see instructions)			0		
h	Administrative service providers (salaries, fees, and commissions) 2h			0		
i	Other expenses			5,993		
j	Total expenses (add lines 2e, 2f, 2g, 2h and 2i) 2j					505,024
k	Net income (loss) (subtract line 2j from line 2d)			,		(329,217)
- 1	Transfers to (from) the plan (see instructions)					(78,965)
3	Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust co by-line basis unless the trust meets one of the specific exceptions described in the instructions.					
	_		Yes	No		Amount
а	· · · · · · · · · · · · · · · · · · ·	3a		х		
b	Employer real property	3b		х		
С	Real estate (other than employer real property)	3c		х		
d	Employer securities	3d		х		
е	Participant loans	3e		х		

	Schedule I (Form 5500) 2009	Pag	je 2- [
			Yes	No	Amount
3f	Loans (other than to participants)	3f	105	X	Amount
		3g	 	$\frac{1}{x}$	
g	Tangible personal property	<u> </u>	<u> </u>	1	
Part	Compliance Questions				
4	During the plan year:		Yes	No	Amount
а	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)	4a		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 participants' account balance	4b		x	· · · · · · · · · · · · · · · · · · ·
		75	-	 ^ 	
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		x	<u> </u>
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions				
	reported on line 4a.)	4d		X	
е	Was the plan covered by a fidelity bond?	4e	х		10,000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		x	
9	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?	4g		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?	4h		x	
:	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?	4i		х	
	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan,				
	or brought under the control of the PBGC?	<u>4j</u>		х	
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 the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	x		
1	Has the plan failed to provide any benefit when due under the plan?	41		х	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	4m		x	
	2520.101-3.)	400		 ^ -	
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	4n			
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 \dots \overline{x}	es _	_] No	Amount:	(
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identifi	y the pl	an(s) to	which assets	or liabilities were
	transferred. (See instructions.)				
	5b(1) Name of plan(s)	5	b(2)	EIN(s)	5b(3) PN(s)
					
		+			
		<u> </u>			l

SCHEDULE R (Form 5500)

Department of the Treasury Internal Revenue Service

Retirement Plan Information

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

2009

OMB No. 1210-0110

	Department of Labor Employee Benefits Security Administration	► File as an Attachment to Form 5500) .				his Form is Op	
	Pension Benefit Guaranty Corporation	<u> </u>				<u> </u>	Inspec	tion.
	er calendar plan year 2009 or fiscal plan	year beginning 01/01/2009 and e	ending 12					
	Name of plan	Associates, PC 401(K)/Profit Sharing Pla	В	Three plan n (PN)	-digit umber	•		001
C	Plan sponsor's name as shown on lin	e 2a of Form 5500	D	Emplo	ver Ide	ntificat	ion Number (FINI
	ortheast Emergency Medical		ال	-	79726		ion (valide) (LIN
	art I Distributions	ASSOCIACES, FC		19-1	19120			-
		nly to payments of benefits during the plan year.	• • • • • • • • • • • • • • • • • • • •					
1		perty other than in cash or the forms of property specified in th	ie	. [1			
2	Enter the EIN(s) of payor(s) who paid payors who paid the greatest dollar a	l benefits on behalf of the plan to participants or beneficiaries d mounts of benefits):	uring the	year (if	more t	han tw	o, enter EINs	of the two
	Profit-sharing plans, ESOPs, and s	etock bonus plans, skip line 3.						
3	· · · · · · · · · · · · · · · · · · ·	eased) whose benefits were distributed in a single sum, during the contract of		. [3			
Pá	art II Funding Information ERISA section 302, skip this	(If the plan is not subject to the minimum funding requirements Part)	s of section	on 412 d	of the Ir	nternal	Revenue Co	de or
4	Is the plan administrator making an e	lection under Code section 412(d)(2) or ERISA section 302(d)((2)?			Yes	☐ No	□ N/A
	If the plan is a defined benefit plan	, go to line 8.						
5		andard for a prior year is being amortized in this the date of the ruling letter granting the waiver. Date:	:	Month		Da	ay Ye	ear
	If you completed line 5, complete l	ines 3, 9, and 10 of Schedule MB and do not complete the	remainde	er of th	is sch	dule.		
6	a Enter the minimum required control	ribution for this plan year		•	6a			
	b Enter the amount contributed by	the employer to the plan for this plan year		·	6b			
	C Subtract the amount in line 6b fro (enter a minus sign to the left of a	om the amount in line 6a. Enter the result a negative amount)		. [6c			
	If you completed line 6c, skip lines	8 and 9.						
7	Will the minimum funding amount rep	orted on line 6c be met by the funding deadline?	• • •	•		Yes	☐ No	□ N/A
8		was made for this plan year pursuant to a revenue procedure proced		•		Yes	□ No	□ N/A
Pá	art iii Amendments							
9		n, were any amendments adopted during this plan value of benefits? If yes, check the appropriate	Increase	• 🗆	Decre	ase	☐ Both	☐ No
Pa	ESOPs (see instructions skip this Part.	s). If this is not a plan described under Section 409(a) or 4975(e	e)(7) of th	e Intern	al Rev	enue C	Code,	
10	Were unallocated employer securities	s or proceeds from the sale of unallocated securities used to re	pay any e	exempt	loan?		. 🔲 Yes	☐ No
	a Does the ESOP hold any preferre						. 🔲 Yes	☐ No
	• •	xempt loan with the employer as lender, is such loan part of a '			an?	• •	Yes	☐ No
12	2 Does the ESOP hold any stock that is	s not readily tradable on an established securities market?					. 🗌 Yes	☐ No

	Schedule R (Form 5500) 2009 Page 2-
Part	V Additional Information for Multiemployer Defined Benefit Pension Plans
	ter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in lars). See instructions. Complete as many entries as needed to report all applicable employers.
а	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
е	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).) (1) Contribution rate (in dollars and cents) (2) Base unit measure: Hourly Weekly Unit of production Other (specify):
а	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
е	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).) (1) Contribution rate (in dollars and cents) (2) Base unit measure: Hourly Weekly Unit of production Other (specify):
а	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
ę	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).) (1) Contribution rate (in dollars and cents)
	(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
а	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
е	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).) (1) Contribution rate (in dollars and cents)

C Dollar amount contributed by employer

Other (specify):

C Dollar amount contributed by employer

Month

Month

Day

Year

Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box

Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box

Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise,

Contribution rate information(if more than one rate applies, check this box 🔲 and see instructions regarding required attachment. Otherwise,

(2) Base unit measure: Hourly Weekly Unit of production

(2) Base unit measure: Hourly Weekly Unit of production

and see instructions regarding required attachment. Otherwise, enter the applicable date.)

and see instructions regarding required attachment. Otherwise, enter the applicable date.)

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

Name of contributing employer

complete items 13e(1) and 13e(2).)
(1) Contribution rate (in dollars and cents)

complete items 13e(1) and 13e(2).)
(1) Contribution rate (in dollars and cents)

Name of contributing employer

b EIN

b EIN

	Schedule R (Form 5500) 2009 Page 3		
14	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the partipant 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 employer contribution during the current plan year to:	an	
	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:		
	Enter the number of employers who withdrew during the preceding plan year	16a	11 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	b If item 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, che supplemental information to be included as an attachment.	ck box and	see instructions regarding
Pa	art VI Additional Information for Single-Employer and Multiemployer Defined Ben	efit Pen	sion Plans
18		art) of liabil ructions reg	ities to such participants parding supplemental
19	If the total number of participants is 1,000 or more, complete items (a) through (c)		
	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-yeild debt: 0-3 years 3-6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-	21 years	21 years or more
	C What duration measure was used to calculate item 19(b)? ☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):		

Form 5558 (Rev. January 2008) Department of the Treasury Internal Revenue Service

Signature ►

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

File With IRS Only

me of filer, plan administrator, or plan sponsor (see instructions)		fying number ntification num	(see instruction ber (EIN).	ons).
mber, street, and room or suite no. (If a P.O. box, see instructions.)	14-17972	263		
O BOX 1568	Social security	y number (SSI	۱)	
y or town, state and ZIP code				
	Plan	Dia	n voar ondi	na
Plan name	number		DD DD	YYYY
	1 1			
ortheast Emergency Medical Associates, PC 40	0 0 1	12	31	2009
	1			
			ļ	
	ingo instructions)			
Extension of time to file Form 5500 of Form 5500-E2 (see instructions)			
equest an extension of time until 10 / 15 / 2010 to file F	Form 5500 or Form 550	0-EZ.		
				2
u must attach a copy of this Form 5558 to each Form 5500 and 5500-	EZ filed after the due	date for the	plans listed	in C abov
the state of the s	00 or Corm 5500 E7			
	O OF FORM SOUPLE.			
Extension of Time to File Form 5330 (see instructions)	*			
		e of Form 53	330.	
er the Code section(s) imposing the tax	. ▶ <u>a</u>			
er the payment amount attached		>	b	
excise taxes under section 4980 or 4980F of the Code, enter the revision ate in detail why you need the extension	/amendment date .	▶	С	
				- Wilders
	O BOX 1568 y or town, state and ZIP code LIFTON PARK NY 12065 Plan name Ortheast Emergency Medical Associates, PC 4C Extension of Time to File Form 5500 or Form 5500-EZ (equest an extension of time until 10 / 15 / 2010 to file File application is automatically approved to the date shown on line 1 (abornal due date of Form 5500 or 5500-EZ for which this extension is request in the normal due date. In must attach a copy of this Form 5558 to each Form 5500 and 5500- Extension of Time to File Form 5330 (see instructions) Quest an extension of time until 10 / 10 / 10 / 10 / 10 / 10 / 10 / 10	O BOX 1568 y or town, state and ZIP code LIFTON PARK Plan name Plan number Ortheast Emergency Medical Associates, PC 40 Extension of Time to File Form 5500 or Form 5500-EZ (see instructions) Equest an extension of time until 10 / 15 / 2010 to file Form 5500 or It all the Form 5500 or Form 5500 or Form 5500 or Form 5500 or It all the Form 5500 or Form 550	O BOX 1568 y or town, state and ZIP code LIFTON PARK Plan name Plan number Plan number MM Optheast Emergency Medical Associates, PC 40 Extension of Time to File Form 5500 or Form 5500-EZ (see instructions) I guest an extension of time until 10 / 15 / 2010 to file Form 5500 or Form 5500-EZ. The application is automatically approved to the date shown on line 1 (above) if: (a) the Form 5558 is filled on or mal due date of Form 5500 or 5500-EZ for which this extension is requested, and (b) the date on line 1 is not not after the normal due date. The unust attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filled after the due date for the grature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ. Extension of Time to File Form 5330 (see instructions) Quest an extension of time until 10 file Form 5330, after the normal due date of Form 5340. The Code section(s) imposing the tax 10 file Form 5330, after the normal due date of Form 5340. The Code section(s) imposing the tax 10 file Form 5330, after the normal due date of Form 5340. The Code section(s) imposing the tax 10 file Form 5330, after the normal due date of Form 5340. The Code section(s) imposing the tax 10 file Form 5330, after the normal due date of Form 5340. The Code section(s) imposing the tax 10 file Form 5330, after the normal due date of Form 5340. The Code section 4980 or 4980 for the Code, enter the revision/amendment date 10 file Form 5340.	y or town, state and ZIP code LIFTON PARK Plan name Plan Plan year endinumber Plan number Plan Plan Plan year endinumber Plan NMM DD Dettheast Emergency Medical Associates, PC 4(0 0 0 1 12 31 Extension of Time to File Form 5500 or Form 5500-EZ (see instructions) Equest an extension of time until 10 / 15 / 2010 to file Form 5500 or Form 5500-EZ. Eapplication is automatically approved to the date shown on line 1 (above) if: (a) the Form 5558 is filed on or before the mal due date of Form 5500 or 5500-EZ for which this extension is requested, and (b) the date on line 1 is no more the 2 1/ in this after the normal due date. In must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed (anature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ. Extension of Time to File Form 5330 (see instructions) quest an extension of time until to file Form 5330. In may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330. In may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330. In the Code section(s) imposing the tax