	Form 5500-SF	yee	OMB Nos. 1210-0110 1210-0089							
	Department of the Treasury Internal Revenue Service		Benefit	Plan ctions 104 and 4065 of the Employe	2009					
E	Department of Labor mployee Benefits Security Administration	Retirement Income Security A Internal R	This Form is Open to Pul							
F	Pension Benefit Guaranty Corporation	0-SF.	Inspection							
Part I Annual Report Identification Information For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009										
_		mployer plan (not multiemployer)								
	This return/report is for:	single-employer plan	one-participant plan							
В	This return/report is for:	☐ first return/report ☐ final return/report								
~		an amended return/report short plan year return/report (less than 12 months) Form 5558 automatic extension								
C	C Check box if filing under: SForm 5558 automatic extension DFVC program									
Part II Basic Plan Information—enter all requested information										
	Name of plan	nation —enter all requested information	ation		1b	Three-digit				
	-	R MEDICINE, P.C. 401 (K) PROFIT	SHARING	PLAN		plan number (PN) ▶ 002				
					1c	Effective date of plan 01/01/2002				
	Plan sponsor's name and addre	ess (employer, if for single-employer R MEDICINE	plan)		2b	Employer Identification Number (EIN) 11-3394918				
	BROADWAY, SUITE A				2c	Plan sponsor's telephone number 631-264-2424				
	TYVILLE, NY 11701				2d	Business code (see instructions) 621111				
	Plan administrator's name and ITH SHORE CARDIOVASCULA		VAY, SUIT	ΈA	3b	Administrator's EIN 11-3394918				
		AMITYVILLE		3c	Administrator's telephone number 631-264-2424					
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. Sponsor's name						EIN				
	name, EIN, and the plan numbe	r from the last return/report. Sponso	rs name		4c	PN				
5a Total number of participants at the beginning of the plan year						17				
b	Total number of participants at	the end of the plan year		5a 5b	16					
C	Total number of participants wi complete this item)	th account balances as of the end of	the plan y	ear (defined benefit plans do not	5c	16				
6a	Were all of the plan's assets d	uring the plan year invested in eligibl	e assets?	(See instructions.)		Yes No				
b		e annual examination and report of a								
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)									
Pa	art III Financial Informa									
7	Plan Assets and Liabilities			(a) Beginning of Year		(b) End of Year				
а	Total plan assets		7a	1014657	7	1387723				
b	Total plan liabilities		7b	C	0					
C	Net plan assets (subtract line 7	e 7b from line 7a) 7c 1014657								
8			7c	1014657	7	1387723				
-	Income, Expenses, and Transf	ers for this Plan Year	7c	1014657 (a) Amount	,	1387723 (b) Total				
а	Contributions received or recei	ers for this Plan Year vable from:								
_	Contributions received or recei (1) Employers	ers for this Plan Year vable from:	8a(1)	(a) Amount 36484	6					
_	Contributions received or recei (1) Employers (2) Participants	ers for this Plan Year vable from:	8a(1) 8a(2)	(a) Amount	4					
_	 Contributions received or received (1) Employers	ers for this Plan Year vable from:	8a(1)	(a) Amount 36484 113073	F 3					
a	Contributions received or recei (1) Employers	ers for this Plan Year vable from:	8a(1) 8a(2) 8a(3)	(a) Amount 36484 113073 0	F 3					
a b	Contributions received or received (1) Employers	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) vollovers and insurance premiums	8a(1) 8a(2) 8a(3) 8b 8c	(a) Amount 36484 113073 0 223509	Image:	(b) Total				
a b c d	Contributions received or received (1) Employers	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) ollovers and insurance premiums	8a(1) 8a(2) 8a(3) 8b 8c 8c	(a) Amount 36484 113073 0 223509 0	I J J J J J	(b) Total				
a b c	Contributions received or rece	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) ollovers and insurance premiums ive distributions (see instructions)	8a(1) 8a(2) 8a(3) 8b 8c 8c 8d 8e	(a) Amount 36484 113073 0 223509		(b) Total				
a b c d e f	Contributions received or rece	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) rollovers and insurance premiums ive distributions (see instructions) s (salaries, fees, commissions)	8a(1) 8a(2) 8a(3) 8b 8c 8c 8d 8c 8d 8e 8f	(a) Amount 36484 113073 0 223509 0 0 0 0 0 0 0 0 0 0 0 0 0		(b) Total				
a b c d e	Contributions received or rece	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) ollovers and insurance premiums ive distributions (see instructions)	8a(1) 8a(2) 8a(3) 8b 8c 8c 8d 8e	(a) Amount 36484 113073 0 223509 0 0 0 0 0 0 0 0 0 0 0 0 0		(b) Total				
a b c d f g	Contributions received or rece	ers for this Plan Year vable from: 8a(2), 8a(3), and 8b) ollovers and insurance premiums ive distributions (see instructions) s (salaries, fees, commissions)	8a(1) 8a(2) 8a(3) 8b 8c 8c 8c 8c 8c 8c 8c 8c 8c 8c 8d 8e 8f 8g 8h	(a) Amount 36484 113073 0 223509 0 0 0 0 0 0 0 0 0 0 0 0 0		(b) Total 373066				

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

Page 2-1

Part IV Plan Characteristics

- **9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2A 2E 2G 2J 2K 3D
- **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part	V Compliance Questions								
10	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.)			Х					
С	Was the plan covered by a fidelity bond?							300000	
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?								
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	Has the plan failed to provide any benefit when due under the plan?	10f		Х					
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g	Х					22454	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		Х					
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	10i							
Part	VI Pension Funding Compliance								
11									
12									
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)								
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruct granting the waiver								
lf y	rou 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									
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	١	lo	N/A	
Part	VII Plan Terminations and Transfers of Assets								
13a	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	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought u of the PBGC?	Inder	the co				Yes	X No	
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify th which assets or liabilities were transferred. (See instructions.)								
1	3c(1) Name of plan(s):		130	:(2) El	N(s)		3c(3)	PN(s)	
Caut	on: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable	e cau	se is i	establ	ished	1			

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.

SIGN	Filed with authorized/valid electronic signature.	10/06/2010	DR. JOHN A. RUISI
HERE	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

Form	Form 5500-SF Short Form Annual Return/Report of Small Employed					OMB Not. 1210-0110 1210-0069				
Ospanima Internal F	Department of the Treesury Internet Revenue Service This form is required to be filed under sections 104 and 4065 of the Employ					2009				
	ment of Labor Is Security Administration	Retirement income Security Internal		This Form i	Open to Public					
	Guintinty Corporation	LRF		pection						
Parti A	nnual Report Id	entification information		the instructions to the Form 580			<u> </u>			
			01/01/2	009 and ending		12/31/200	9			
A This return	/report is for;	X single-employer plan] multiple-e	mployer plan (not multiemployer)		one-participa	nt plan			
B This return	/report is for;	first return/report] final retur	n/report						
	[an amended return/report] short plan	year return/report (less than 12 moi	t hs)					
C Check box	If filing under:	X Form 5658] sutomatic	extension		DEVC progra	m			
		special extension (enter descripti	lon)			_				
Part II E	lasic Plan Inform	nation enter all requested infom	nation			· · · · · · · · · · · · · · · · · · ·				
12 Name of plan South Shore Cardiovascular Medicine, P.C.						Three-digit				
						pìan number (PN) ▶	002			
401 (k	> Profit Shar	ring Plan			1c	Effective date o				
			-			01/01/200				
2a Plan spon	sor's name and addn	ess (employer, if for single-employe /ascular Medicine	r plan)		2b	Employer identi				
					2-	(EIN) 11-339	elephone number			
137 Br	oadway, Suite	Α			20	(631)264-2				
					2d	Business code (621111	see Instructions)			
Amityv 38 Plan admi		address (if same as Plan sponsor, o	Anler "Same	NY 11701	-th	Administrator's				
SANE				,						
					3ç	Administrator's	elephone number			
4 If the name	and/or EIN of the pla	an sponsor has changed since the la	ust neturn/re	port filed for this plan, enter the	4b EIN					
		r from the last return/report. Spons								
En Total aun					40	PN				
5a Totel number of participants at the beginning of the plan year					5 a		17			
 b Total number of participants at the end of the plan year C Total number of participants with account balances as of the end of the plan year (defined banafit plans do not 					5b		16			
complete	this item)	In account dalances as of the end of	a the plan y	ear (defined benefit plans do not	5c		16			
				(See instructions.)		*** *********	X Yes No			
b Are you d	laiming a waiver of t	he annual examination and report of	f an indecer	ndent qualified public accountant (IQ	PA)					
Under 29 If you site	CFR 2520,104-467 (typend "No" to eith	See instructions on waiver aligibility	and conditi	ona.). SF and must instead use Form 55		•••••••••••••••	X Yes No			
	inencial informa			or and must network use Form of	Ν.					
	its and Liabilities		T	(a) Beginning of Year		(b) End	of Year			
 Total plan 	assets			1,014,65	7		1,387,723			
b Total plan	llabilities				0		0			
C Net plan a	ssets (subtract line 7	'b from line 7a)	7c	1,014,65	7		1,387,723			
	•	ers for this Plan Year		(a) Amount		(0) 1	otal			
	ons received or recei			36,48						
			P	113,07						
	•)			1					
·		/		223,50	9					
		8a(2), 6a(3), and 6b)					373,066			
d Benefits p	aid (including direct)	rollovers and insurance premiums			1-		· · · · ·			
		······			<u>0</u>	•				
		ive distributions (see instructions) s (salaries, fees, commissions)			뵈		•			
		* (salaries, tees, commissions)			1					
		Be, 6f, and 8g)			╧╋					
		a 8h from (ine 5c)				· · · · · · · · · · · · · · · · · · ·	373,066			
		e instructions)			0	······				
For Paperwork R	eduction Act Notice and	ONE Control Numbers, see the Instruct			-		Form 6500-8F (2008)			
							V.092308.1			

Form 5500-8F 2009

Part IV	Plan	Characteristics	R

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

 2A
 2E
 2G
 2J
 2K
 3D

Page 2-

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

Part	V Compliance Questions							
10	During the plan year,		Yes	No		A	nount	
	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-1027 (See Instructions and DOL's Voluntary Fiduciary Correction Program)	10a	*******	x				Januari, second s
þ	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported	10ь		x				,
C		10c	x				31	10,00
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				
9	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	10e		x		•••		
f	blue the plan failed to any idea and to an due to the to the plant of the second	107		x				·
g		10a	x					
ĥ	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	10g	~	x				22,45
1	If 10h was answered "Yes," check the box if you either provided the required notice or one of the	101		~	·			
Part	VI Pension Funding Compliance							A-1
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and comp	lets !	Sched	ule S8	(Form			<u> </u>
12	5500))					-		No X No
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruct granting the waiver	ions, 1	and e	nter Ih Day	e date of			
b	Enter the minimum required contribution for this plan year		[126				
C	Enter the amount contributed by the employer to the plan for this plan veer			12c				
đ	Subtract the amount in line 12¢ from the amount in line 12b. Enter the result (enter a minus sign to the left of negative amount)	fa		12d				
	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	Π	No [N∕A
Part '								
13a	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.		Г	13a				-bed. man
Þ	Were all the plan assets distributed to participants or banaficiaries, transferred to another plan, or brought up of the PBGC?	nder 1	the co	ntral		[X No
C	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the which assets or liabilities were transferred. (See instructions.)) plan	i(a) to			-	-	_
1	lc(1) Name of plan(a):		130	(2) Ell	N(s)		13c(3)	PN(s)
•								
Cauti	on: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable	Cau	60 is (istații	shed.			
- 340 Gr	penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return Schedule MG completed and signed by an enrolled actuary, as well as the electronic version of this return/re it is true, correct, and complete.	n/rep sport,	ort, in and t	ciuding o the b	, if appik est of my	icno	, a Schi wiedge	idule and

SIQN HERE	Signature of plan administrator	Date 9 128/10	Dr. John A. Ruisi
SIGN			Enter name of Individual signing as plan administrator
HERE	algneture of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor