## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation 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).

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2009

OMB Nos. 1210-0110 1210-0089

This Form is Open to Public Inspection

|            | ension Be  | enefit Guaranty Corporation | ▶ Complete all entrie         | es in accor    | dance witl          | h the instructions to the Form 550    | 0-SF.    |                       |         |        |
|------------|--|-----------------------------|-------------------------------|----------------|---------------------|---------------------------------------|----------|-----------------------|---------|--------|
|            | art I  |                             | Identification Inform         |                |                     |                                       |          |                       |         | •      |
| For        | calend   | lar plan year 2009 or fis   | cal plan year beginning       | 01/01/200      | 9                   | and ending                            | 2/31/2   | 2009                  |         |        |
| Α.         | This ret   | turn/report is for:         | X single-employer plan        |                | multiple-e          | employer plan (not multiemployer)     |          | one-participa         | nt plan |        |
| В          | This return/report is for: first return/report final return/report |                             |                               |                |                     |                                       | _        |                       |         |        |
|            |  |                             | an amended return/rep         | port           | short plan          | year return/report (less than 12 mo   | nths)    |                       |         |        |
| C          | C Check box if filling under:                                      |                             |                               |                |                     | extension                             |          | DFVC progra           | ım      |        |
|            |  | -                           | special extension (ente       | er description | on)                 |                                       |          | _                     |         |        |
| Pa         | rt II  | Basic Plan Info             | rmation—enter all reque       | sted inform    | ation               |                                       |          |                       |         |        |
|            |  | of plan                     |                               |                |                     |                                       | 1b       | Three-digit           |         |        |
|            |  | •                           | C 401K PROFIT SHARING         | G PLAN &       | TRUST               |                                       |          | plan number           | 001     |        |
|            |  |                             |                               |                |                     |                                       |          | (PN) <b>•</b>         |         |        |
|            |  |                             |                               |                |                     |                                       | 1C       | Effective date o      |         |        |
| 2a         | Plan s   | nonsor's name and add       | dress (employer, if for singl | e-employer     | nlan)               |                                       | 2b       | Employer Identi       |         | nher   |
|            |  | . DEMATTEO, MD, PLI         | ` ' ' ' '                     | o citipioyei   | pian)               |                                       | ~        | (EIN) 13-406          |         | IIDCI  |
|            |  |                             |                               |                |                     |                                       | 2c       | Plan sponsor's t      |         | umber  |
|            |  | H BROADWAY<br>NY 10701      |                               |                |                     |                                       | 24       | 914-96                |         | ··     |
| 1011       | rtErto,  | 141 10701                   |                               |                |                     |                                       | 20       | Business code (621111 |         | tions) |
| 3a         | Plan a   | administrator's name an     | d address (if same as Plan    | sponsor, e     | nter "Same          | e")                                   | 3b       | Administrator's       |         |        |
| ROB        | ERT E.   | . DEMATTEO, MD, PLI         |                               | 70 NORTH       |                     | AY                                    |          | 13-406                |         |        |
|            |  |                             | '                             | OTTICE TO, I   | 141 10701           |                                       | 3c       | Administrator's 1     |         | ıumber |
| <b>4</b> I | f the na   | ame and/or EIN of the p     | plan sponsor has changed      | since the la   | st return/re        | port filed for this plan, enter the   | 4b       | EIN                   |         |        |
|            | name, l  | EIN, and the plan numb      | per from the last return/repo | ort. Sponso    | or's name           |                                       |          |                       |         |        |
|            | Tatal  |                             |                               |                |                     |                                       | 4c       | PN<br>T               |         |        |
|            |  |                             |                               |                |                     |                                       | 5a       |                       |         | 3      |
| b          |  |                             |                               |                |                     |                                       | 5b       |                       |         | 3      |
| С          |  |                             |                               |                |                     | rear (defined benefit plans do not    | 5c       |                       |         | 3      |
| 6a         | Were   | all of the plan's assets    | during the plan year inves    | ted in eligib  | le assets?          | (See instructions.)                   |          |                       | X Yes   | No     |
| b          |  |                             |                               |                |                     | ndent qualified public accountant (IQ |          |                       |         |        |
|            |  |                             |                               |                |                     | ons.)                                 |          |                       | X Yes   | No     |
| Da         | rt III   | Financial Inform            |                               | nnot use F     | orm 5500-           | SF and must instead use Form 55       | ου.      |                       |         |        |
|            |  |                             | ilation                       |                |                     | (a) Denimalan at Vern                 |          | /b) F., .1            | - ( ) ( |        |
| 7          |  | Assets and Liabilities      |                               |                | 7-                  | (a) Beginning of Year<br>46253        | 5        | (b) End               |         | 702258 |
| a<br>b     |  | p.a accord                  |                               |                | . <u>7a</u><br>. 7b |                                       | 0        |                       |         | 0      |
| C          |  | •                           | 2 7b from line 7a)            |                |                     | 46253                                 |          |                       |         | 702258 |
| 8          |  |                             | sfers for this Plan Year      |                | . 7с                |                                       | <u> </u> | (b) 7                 |         | 102230 |
| а          |  | ibutions received or rec    |                               |                |                     | (a) Amount                            |          | (b) 1                 | Otai    |        |
| _          |  |                             |                               |                | . 8a(1)             | 933                                   | 1        |                       |         |        |
|            | <b>(2)</b> P   | articipants                 |                               |                | . 8a(2)             | 1066                                  | 9        |                       |         |        |
|            | (3) 0  | thers (including rollove    | rs)                           |                | . 8a(3)             |                                       | 0        |                       |         |        |
| b          | Other  | income (loss)               |                               |                | . 8b                | 23030                                 | 4        |                       |         |        |
| С          | Total i  | income (add lines 8a(1      | ), 8a(2), 8a(3), and 8b)      |                | . 8c                |                                       |          |                       |         | 250304 |
| d          |  |                             | t rollovers and insurance p   |                | . 8d                |                                       | 0        |                       |         |        |
| е          |  |                             | ctive distributions (see inst |                | . 8e                |                                       | 0        |                       |         |        |
| f          | Admir  | nistrative service provid   | ers (salaries, fees, commis   | ssions)        | . 8f                |                                       | 0        |                       |         |        |
| g          | Other  | expenses                    |                               |                | . 8g                | 1058                                  | 1        |                       |         |        |
| h          | Total  | expenses (add lines 8d      | , 8e, 8f, and 8g)             |                |                     |                                       |          |                       |         | 10581  |
| i          | Net in   | ncome (loss) (subtract li   | ne 8h from line 8c)           |                | . 8i                |                                       |          |                       |         | 239723 |
| j          |  |                             | see instructions)             |                |                     |                                       | 0        |                       |         |        |

| Dort IV | Dian | Charac | teristics  |
|---------|------|--------|------------|
| Part IV | Plan | Charac | 'teristics |

HERE

SIGN HERE Signature of plan administrator

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 2J 3B 3D

| Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Fo. 5500))   | ) li                               | If th  | e plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Charact   | terist   | ic Cod                                       | des in                           | the inst | ructions | i:    |       |
|--|------------------------------------|--|--|--|--|----------------------------------|----------|----------|-------|-------|
| 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)   | art '                              | t V  | Compliance Questions   |  |  |                                  |          |          |       |       |
| b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)  | )                                  | Dι   | ing the plan year:   |  | Yes  | No                               |          | Am       | ount  |       |
| on line 10a.)  | а                                  |  |  | X  |  |                                  |          |          |       |       |
| d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?  e 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.)  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.)  |                                    |  |  | ns with any party-in-interest? (Do not include transactions reported |  |                                  |          |          |       |       |
| e 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.)  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.)  | С                                  | W  | s the plan covered by a fidelity bond?   | 10c  | X  |                                  |          |          |       | 50000 |
| f Has the plan failed to provide any benefit when due under the plan? (See Instructions.)  |                                    |  |  |  |  |                                  |          |          |       |       |
| g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)  |                                    | ins  | 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   |  |  |                                  |          |          |       |       |
| h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)  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  | f                                  | Ha   | the plan failed to provide any benefit when due under the plan?  | 10f  |  | X                                |          |          |       |       |
| 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   | g                                  | Di   | the plan have any participant loans? (If "Yes," enter amount as of year end.)  | 10g  |  | X                                |          |          |       |       |
| exceptions to providing the notice applied under 29 CFR 2520.101-3   |                                    |  |  | 10h  |  | Χ                                |          |          |       |       |
| Pension Funding Compliance   It is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Fo. 5500))   |                                    |  |  | 10i  |  |                                  |          |          |       |       |
| Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (F-5500))   |                                    |  |  |  |  |                                  |          |          |       |       |
| Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERI (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)  a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the d granting the waiver  | 1                                  | Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form |  |  |  |                                  |          |          |       |       |
| (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)  a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the d granting the waiver   |                                    |  |  |  |  |                                  |          |          |       | X No  |
| a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the d granting the waiver   |                                    |  |  |  |  |                                  |          |          |       |       |
| granting the waiver  |                                    |  |  |  |  |                                  |          |          | ina   |       |
| b Enter the minimum required contribution for this plan year   | granting the waiver Month Day Year |  |  |  |  |                                  |          |          |       |       |
| c Enter the amount contributed by the employer to the plan for this plan year  |                                    | -  |  |  |  | 401                              | l        |          |       |       |
| 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?  art VII Plan Terminations and Transfers of Assets  3a Has a resolution to terminate the plan been adopted during the plan year or any prior year?  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?  C If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.) |                                    |  |  |  |  | 12C                              |          |          |       |       |
| art VII Plan Terminations and Transfers of Assets  3a Has a resolution to terminate the plan been adopted during the plan year or any prior year?  | ı                                  | ne   | ative amount)  |  | <u>.                                    </u> |                                  |          |          |       | 7     |
| Has a resolution to terminate the plan been adopted during the plan year or any prior year?  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?  If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)   |                                    |  | T  |  |  |                                  | Yes      | 3        | No    | N/A   |
| b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?  If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)   | ırt \                              | t VII  | Plan Terminations and Transfers of Assets  |  |  |                                  |          |          |       | _     |
| b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?  | a                                  | Ha   | a resolution to terminate the plan been adopted during the plan year or any prior year?  |  |  |                                  | 1        |          | Yes   | X No  |
| of the PBGC?  If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)  |                                    | lf "   | es," enter the amount of any plan assets that reverted to the employer this year   |  |  | 13a                              |          |          |       |       |
| which assets or liabilities were transferred. (See instructions.)  |                                    |  |  |  |  |                                  |          |          |       |       |
| <b>13c(1)</b> Name of plan(s): <b>13c(2)</b> EIN(s   |                                    |  |  |  |  |                                  |          |          |       |       |
|  | 13c(1) Name of plan(s):            |  |  |  |  | <b>13c(2)</b> EIN(s) <b>13c(</b> |          |          |       | PN(s) |
|  |                                    |  |  |  |  |                                  |          |          |       |       |
|  |                                    |  |  |  |  |                                  |          |          |       |       |
|  |                                    |  | A constitution that the second of the second |  |  | 4-1-1                            |          |          |       |       |
| Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is establish<br>Inder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if   |                                    |  | · · · · · · · · · · · · · · · · · · ·  |  |  |                                  |          | oliooblo | a Cah | adule |
| onder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, in 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 belief, it is true, correct, and complete.  | 3 or                               | or Šc  | redule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/re   |  |  |                                  |          |          |       |       |
| SIGN Filed with authorized/valid electronic signature. 10/15/2010 ROBERT E. DEMATTEO   | IGN                                | :N   | iled with authorized/valid electronic signature. 10/15/2010 ROBERT E. DEMA   | ATTE   | 0  |                                  |          |          |       |       |

Date

Date

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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).

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

OMB Nos. 1210-0110 1210-0089

2009

This Form is Open to Public Inspection

|        | art I Annual Report Identification Information  |             |  |       |                    |                                  |
|--------|---|-------------|--|-------|--------------------|----------------------------------|
| For    | calendar plan year 2009 or fiscal plan year beginning 0   | 1/01/2      | 009 and ending                         |       | 12/31/2009         | <u> </u>                         |
| A      | This return/report is for:  | multiple-e  | mployer plan (not multiemployer)       |       | one-participant    | plan                             |
| _3.7   | This return/report is for:   first return/report  | n/report    |  | _     |                    |                                  |
| _      | an amended return/report  | nths)       |  |       |                    |                                  |
| _      | 님   | •           | n year return/report (less than 12 moi | 1110) | □ DEVC =======     |                                  |
| C      | Check box if filing under: X Form 5558  |             | extension                              |       | DFVC program       |                                  |
|        | special extension (enter description  |             |  |       |                    | <u> </u>                         |
| Pa     | art II Basic Plan Information—enter all requested information   | ation       |  |       |                    |                                  |
|        | Name of plan  |             |  | 1b    | Three-digit        |                                  |
|        | ROBERT E. DEMATTEO, MD, PLLC 401K PROFIT  | SHARI       | NG                                     |       | plan number        | 001                              |
|        | PLAN & TRUST  | 10          | (PN) ▶ Effective date of p             | ,     |                    |                                  |
|        |   |             |  | 10    | 01/01/1999         | oian                             |
| 22     | Plan sponsor's name and address (employer, if for single-employer                                       | nlan)       |  | 2h    | Employer Identific | ation Number                     |
|        | Plan sponsor's name and address (employer, if for single-employer ROBERT E. DEMATTEO, MD, PLLC          | piani       |  |       | (EIN) 13-4068      |                                  |
|        |   |             |  | 2c    | Plan sponsor's tel | ephone number                    |
|        | 970 NORTH BROADWAY  |             |  |       | (914) 965-33       | 366                              |
|        | WONNER O  |             | NV 10702                               | 2d    | Business code (se  | ee instructions)                 |
|        | YONKERS   | ntor "Come  | NY 10701                               | 2 h   | Administrator's El | N1                               |
| Ja     | $\underset{SAME}{\textbf{Plan}}$ administrator's name and address (if same as Plan sponsor, each $SAME$ | nter Same   | <b>;</b> )                             | 30    | Administrator's Er | IN                               |
|        |   |             |  | 3с    | Administrator's te | lephone number                   |
|        |   |             |  |       |                    | •                                |
|        | If the name and/or EIN of the plan sponsor has changed since the las                                    |             | port filed for this plan, enter the    | 4b    | EIN                |                                  |
| ١      | name, EIN, and the plan number from the last return/report. Sponso                                      | 4c          | DNI                                    |       |                    |                                  |
| 52     | Total number of participants at the beginning of the plan year  |             |  |       |                    |                                  |
|        |   |             |  | 5a    |                    |                                  |
|        | Total number of participants at the end of the plan year  |             |  | 5b    |                    | 3                                |
| С      | Total number of participants with account balances as of the end of complete this item)                 |             |  | 5с    |                    | 3                                |
| 62     | Were all of the plan's assets during the plan year invested in eligib                                   |             |  |       |                    | X Yes No                         |
|        | Are you claiming a waiver of the annual examination and report of                                       |             | ,                                      |       |                    |                                  |
| -      | under 29 CFR 2520.104-46? (See instructions on waiver eligibility a                                     |             |  |       |                    | X Yes No                         |
|        | If you answered "No" to either 6a or 6b, the plan cannot use Fo   | orm 5500-   | SF and must instead use Form 55        | 00.   |                    |                                  |
| Pa     | rt III Financial Information  | 1           |  |       |                    |                                  |
| 7      | Plan Assets and Liabilities   |             | (a) Beginning of Year                  |       | (b) End o          | f Year                           |
| а      | Total plan assets   | 7a          | 462,53                                 | 5     |                    | 702,258                          |
| b      | Total plan liabilities  | 7b          |  | 0     |                    | 0                                |
| C      | Net plan assets (subtract line 7b from line 7a)   | 7c          | 462,53                                 | 5     |                    | 702,258                          |
| 8      | Income, Expenses, and Transfers for this Plan Year  |             | (a) Amount                             |       | (b) To             | tal                              |
| а      |   |             |  | _     |                    |                                  |
|        | (1) Employers   | 8a(1)       | 9,33                                   |       |                    |                                  |
|        | (2) Participants  | 8a(2)       | 10,66                                  | 9     |                    |                                  |
|        | (3) Others (including rollovers)  | 8a(3)       |  | 이     |                    |                                  |
| b      | Other income (loss)   | 8b          | 230,30                                 | 4     |                    |                                  |
| C      | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)  | 8c          |  |       |                    | 250,304                          |
| d      | Benefits paid (including direct rollovers and insurance premiums  | يە ا        |  | 0     |                    |                                  |
| _      | to provide benefits)  | 8d          |  | 0     |                    |                                  |
| e      | ,   | 8e          |  | 0     |                    |                                  |
| f<br>~ | Administrative service providers (salaries, fees, commissions)  | 8f          | 10 50                                  | 1     |                    |                                  |
| g      | Other expenses.   | 8g          | 10,58                                  | 1     |                    | 10 50-                           |
| h      | ,   | 8h          |  | _     |                    | 10,581                           |
| ĺ,     | Net income (loss) (subtract line 8h from line 8c)   | 8i          |  | _     |                    | 239,723                          |
| J      | Transfers to (from) the plan (see instructions)   | 8j          |  | 0     |                    |                                  |
| For    | Paperwork Reduction Act Notice and OMB Control Numbers, see the instruction                             | ns for Form | 5500-SF.                               |       | F                  | orm 5500-SF (2009)<br>v.092308.1 |

SIGN HERE

Signature of employer/plan sponsor

1 9149651310

|   |   | Form 5500-SF 2009   | P  | age 2-                                 |         | _        |            |               |         |           |       |
|---|---|---|--|--|---------|----------|------------|---------------|---------|-----------|-------|
| Par   | tΝ  | Plan Characteristics  |  |  |         |          | 1- <u></u> |               |         |           |       |
| 9a  | If ti   | e plan provides pansion benefits, enter the applicable pension fea  | ature codes from the                     | List of Plan Char                      | acteria | stic Co  | rles in    | the instru    | ctions  | :         |       |
| b   | 2E 2J 3B 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  | t V   | Compliance Questions  | -  |  |         | ,        | -          |               |         |           |       |
| 10  | Ouring the plan year:   |   |  |  |         |          |            |               | Amo     | ount      |       |
| a   | 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)  |   |  |  |         |          |            |               |         |           |       |
| b   | b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reporte on line 10a.)  |   |  |  |         |          | х          | 4             |         |           |       |
| C   | W   | as the plan covered by a fidelity bond?   |  |  | 10¢     | х        |            | <b>7</b> 20.  | 909     | .00-5     | 3,000 |
| ٠. <b>d</b>   | Dic<br>or   | the plan have a loss, whether or not reimbursed by the plan's fide  | elity bond, that was                     | caused by fraud                        | 10d     |          | Х          |               |         | ····      |       |
| e   | 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   | Ha  | s the plan failed to provide any benefit when due under the plan?   |  |  | 10f     |          | - х        |               |         |           |       |
| g   | Die   | the plan have any participant loans? (If "Yes," enter amount as o   | f year end.)                             |  | 10g     |          | X          | <b>†</b>      |         |           |       |
| h   |   | niè is an individual account plan, was there a blackout period? (Se   |  |  | 10h     |          | X          |               | •       |           |       |
| i   |   | Oh was enswered "Yes," check the box if you either provided the r   | ,  |  |         |          | -          |               |         |           |       |
|   |   | reptions to providing the notice applied under 29 CFR 2520.101-3  | ***************************************  |  | 101     |          |            | L             |         |           |       |
| Part<br>11  |   | Pension Funding Compliance  is a defined benefit plan subject to minimum funding requirement  | ha / / / / / / / / / / / / / / / / / / / | tourtions and com-                     | minta   | Cabad    | ola CC     | /Earm         |         |           |       |
|   |   | (b)   |  |  |         |          |            |               |         | Yes       | No    |
| 12  | is '  | his a defined contribution plan subject to the minimum funding rec  | quirements of sactio                     | n 412 of the Code                      | or se   | ction 3  | 02 of      | ERISA?        |         | Yes       | X No  |
| a   | lf a  | Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable waiver of the minimum funding standard for a prior year is being a  | amortized in this pla                    |  |         |          |            |               |         |           |       |
| . If s  | gra<br>vou  | nting the waiver  | IR (Form 5500), and                      |  | th      |          | Day        | -             | Yea     | r         |       |
|   |   | er the minimum required contribution for this plan year   |  |  |         |          | 12b        |               |         |           | M. I  |
|   |   | er the amount contributed by the employer to the plan for this plan   |  |  |         |          | 12c        |               |         |           |       |
|   | Sul   | stract the amount in line 12c from the amount in line 12b. Enter the  | e result (enter a min                    | us sign to the left (                  | of a    |          | 12d        |               |         |           | ,,    |
| ę   | Wil   | the minimum funding amount reported on line 12d be met by the   | funding deadline?                        | ************************************** |         |          |            | Yes           |         | lo 🗌      | N/A   |
| Part  | VII   | Plan Terminations and Transfers of Assets   |  |  |         |          |            |               |         |           |       |
| 13a   | Has   | a resolution to terminate the plan been adopted during the plan y   | ear or any prior year                    | r?                                     |         |          |            |               |         | Yes       | X No  |
|   | If "Yes," enter the amount of any plan assets that reverted to the employer this year   |   |  |  |         |          | 158        |               |         |           |       |
|   | b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?   |   |  |  |         |          |            |               |         |           |       |
| C   |   | uring this plan year, any assets or liabilities were transferred from<br>ch assets or liabilities were transferred. (See instructions.)                                     | this plan to another                     | plan(s), identify th                   | e plar  | 1(s) to  |            | <u> </u>      |         | <b></b> . |       |
| 1   | 3c(1  | ) Name of plan(s):  |  |  |         | 13c      | (2) E      | N(s)          |         | 3c(3)     | PN(s) |
|   |   |   |  |  |         |          |            |               |         |           |       |
|   |   |   |  |  |         | <b></b>  |            |               | +       |           | -     |
| Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. |   |   |  |  |         |          |            |               |         |           |       |
| Unde<br>SB or   | r pe<br>r Sci   | naities of perjury and other penalties set forth in the instructions, I<br>sedule MB completed and signed by an anrolled actuary, as well a<br>true, correct, and complete. | declare that I have                      | examined this retu                     | rn/rep  | ort, Inc | diudin     | g, if applica |         |           |       |
| SIGN  |   | Rolux E. D. note MM   | 10-14-10                                 | ROBERT E. I                            | DEMA    | TTEC     |            |               |         |           |       |
| HER   | E   | Signature of plan administrator   | Date                                     | Enter name of in                       | dividu  | al sign  | ing as     | i pian adm    | Inistra | itor      |       |

Date

Enter name of individual signing as employer or plan sponsor