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.

1210-0089

OMB Nos. 1210-0110

2009

This Form is Open to Public Inspection

_	Part I Annual Report Identification Information							
For	r calendar plan year 2009 or fiscal plan year beginning 05/01/	2009	and ending	12/31/	2009			
Α	This return/report is for: X single-employer plan	multiple-e	employer plan (not multiemployer)	er plan (not multiemployer)				
В	This return/report is for:	final retur	n/report		_			
	an amended return/report	X short plar	year return/report (less than 12 m	onths)				
С	Check box if filing under:	automatic	extension		DFVC program			
_	special extension (enter description)	ription)						
P	art II Basic Plan Information—enter all requested inf	· · ·						
	Name of plan			1b	Three-digit			
	JTH SHORE WOMEN'S MEDICAL ASSOCIATES, LLC 401(K)PL	_AN			plan number			
				4-	(PN)			
				10	Effective date of plan 05/01/2009			
	Plan sponsor's name and address (employer, if for single-employer	oyer plan)		2b	2b Employer Identification Number			
500	JTH SHORE WOMENS MEDICAL ASSOCIATES, LLC			(EIN) 01-0820405 2c Plan sponsor's telephone nur				
	MERRICK RD				516-255-2044			
ROC	CKVILLE CENTRE, NY 11570			2d	Business code (see instructions) 621900			
	Plan administrator's name and address (if same as Plan sponso		e")	3b	Administrator's EIN			
500	JTH SHORE WOMENS MEDICAL ASSOCIATES, LLC 566 MER ROCKVII	LLE CENTRE,	NY 11570	3c	01-0820405 Administrator's telephone number			
1	If the name and/or EIN of the plan sponsor has changed since th	o last roturn/ro	port filed for this plan, enter the	4h	516-255-2044			
	name, EIN, and the plan number from the last return/report. Spo		port med for this plan, enter the	40	EIN			
				4c	PN			
5a	Total number of participants at the beginning of the plan year			- 5a	1			
b	Total number of participants at the end of the plan year	5b	1					
С	Total number of participants with account balances as of the er complete this item)			. 5c	1			
6a	Were all of the plan's assets during the plan year invested in e	ligible assets?	(See instructions.)		X Yes No			
b	, ,				X Yes □ No			
	under 29 CFR 2520.104-46? (See instructions on waiver eligible If you answered "No" to either 6a or 6b, the plan cannot us	•	, , , , , , , , , , , , , , , , , , ,		Yes No			
Pa	art III Financial Information	SC 1 01111 3300-	or and must mistead use i orm s					
7	Plan Assets and Liabilities		(a) Beginning of Year		(b) End of Year			
а	Total plan assets	7a	, , , ,	0	538			
b	Total plan liabilities	7b						
С	Net plan assets (subtract line 7b from line 7a)	7с		0 53				
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total				
а		2 (1)						
	(1) Employers		0.0					
	(2) Participants	` '	92	20				
h	(3) Others (including rollovers) Other income (loss)	` ` `	-89	10				
b			-08	99	21			
c d					21			
-	to provide benefits)		-48	32				
е	Certain deemed and/or corrective distributions (see instructions	s) 8e						
f	Administrative service providers (salaries, fees, commissions).	8f	-3	35				
g	Other expenses	8g						
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			-517			
į	Net income (loss) (subtract line 8h from line 8c)				538			
	Transfers to (from) the plan (see instructions)	8j						

Part IV	Dlan	Charac	torictics
Part IV	Plan	Charac	reristics

SIGN HERE

Signature of employer/plan sponsor

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2F 2G 2J 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	٧	Compliance Questions							
10	Dui	ing the plan year:	Yes	No	Amount				
а		s there a failure to transmit to the plan any participant contributions	_	X					
h	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)								
	on line 10a.)				b	X			
С	Wa	s the plan covered by a fidelity bond?		10	С	X			
d		the plan have a loss, whether or not reimbursed by the plan's fidelishonesty?	•	*	d	X			
е	insı	re any fees or commissions paid to any brokers, agents, or other parance service or other organization that provides some or all of the ructions.)	e benefits under the	plan? (See	e X				9
f	Has	the plan failed to provide any benefit when due under the plan?		10	f	X			
g	Did	the plan have any participant loans? (If "Yes," enter amount as of	year end.)	10	a	X			
h		is is an individual account plan, was there a blackout period? (See 0.101-3.)) CFR		X			
i		Oh was answered "Yes," check the box if you either provided the re eptions to providing the notice applied under 29 CFR 2520.101-3			i	X			
Part	VI	Pension Funding Compliance							
11		is a defined benefit plan subject to minimum funding requirements						☐ Yes	X No
12		0))						Yes	
12				1412 of the Code of	section	302 01	ERISA!		ino
2		Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable waiver of the minimum funding standard for a prior year is being an		voor coo instruction	c and	ontor th	o data of th	oo lottor ru	lina
а		nting the waiver.							
lf y	-	completed line 12a, complete lines 3, 9, and 10 of Schedule MB				Í			
b	Ent	er the minimum required contribution for this plan year			[12b			
		er the amount contributed by the employer to the plan for this plan			Т	12c			
	Sub	tract the amount in line 12c from the amount in line 12b. Enter the	result (enter a minu	us sign to the left of a	Ī	12d			
	_	ative amount)			-				<u> </u>
		the minimum funding amount reported on line 12d be met by the fu	unding deadline?				Yes	No	X N/A
Part	VII	Plan Terminations and Transfers of Assets							
3a	Has	a resolution to terminate the plan been adopted during the plan ye	ear or any prior yea	r?			1	Yes	X No
	If "Y	es," enter the amount of any plan assets that reverted to the emplo	oyer this year			13a			
b		e all the plan assets distributed to participants or beneficiaries, transe PBGC?						Yes	X No
С		uring this plan year, any assets or liabilities were transferred from the assets or liabilities were transferred. (See instructions.)	his plan to another	plan(s), identify the p	lan(s) to)			
1	13c(1) Name of plan(s):					c(2) El	N(s)	13c(3)	PN(s)
									_
Cauti	ion:	A penalty for the late or incomplete filing of this return/report v	will be assessed u	ınless reasonable c	ause is	establ	ished.		
Unde SB o	r per Sch	nalties of perjury and other penalties set forth in the instructions, I dedule MB completed and signed by an enrolled actuary, as well as true, correct, and complete.	leclare that I have e	examined this return/	eport, i	ncludin	g, if applica		
SIGI	, F	iled with authorized/valid electronic signature.	01/11/2011	FRANK HARRISON					
HER					idual signing as plan administrator				

Date

Enter name of individual signing as employer or plan sponsor

01/11/2011 10:27 FAX

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Form 5500-SF

Department of the Transury Internal Revenue Service

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

OMB Nos. 1210-0110 1210-0089

2009

-	Department of Leaser Inchange Benefits Security Administration Innsien Benefit Guaranty Corporation	This Form is Open to Public inspection							
,—				the Instructions to the Form 5500	-SF.	<u> </u>			
		ientification Information		AA		# 1 / 2 1 / 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
- POF	calendar plan year 2009 or fisc		05/01/20			12/31/2009			
Α΄	This return/report is for; .	X single-employer plan	, Tunitible-et	nployer plan (not multlemployer)		L one-porticipant plan			
В	This return/report is for:	X first return/report	[] final return	/report		% .			
		an amunded return/report	X short plan	year return/report (less than 12 mor	ithe)	∯.			
C	Check box If filing under:	Form 5558	utomatic	extension		DFVC program			
_	Crisca 232 in hining drider.	special extension (enter depor				, and the same of			
			. ,	<u> </u>					
		mation—enter all requested inf	ormation		45				
та	Name of plan SOUTH SHORE WOMEN'S	S MEDICAT.			110	. Three-digit .ptn number			
			•			(PN) ▶ 001			
	ASSOCIATES, LLC				10	Effective date of plan			
	401 (K) PLAN		•			05/01/2009			
2a	Plan sponsor's name and addr	eşn (employer, if for single-employer) MEDICAL	oyer plan)		2Ь	Employer Identification Number	ar		
	ASSOCIATES, LLC	MEDICAL			_	(E(N) 01-0020405			
	*	√ ·	•		2c	Plan sponsor's telephone num (\$16) 255-2044	ber		
	566 MERRICK RD				24	Business code (see instruction	<u></u>		
	ROCKVILLE CENTRE		•	NY 11570	20	621900	14)		
3a		address (if same as Plan spons	dr. enter "Samo		3b	Administrator's EIN			
	EVHE		,			1.			
					3с	Administrator's telephone num	iber		
_					***************************************				
		an sponsor has changed since the		port filed for this plan, enter the	4b EN				
	ining, Env. and the plan number	or from the last return/report. Sp.	onsor's name		4c 👸				
5a	Total number of porticipants a								
b			<u> </u>						
		"			5b	<u>19</u>			
С				ear (defined henefit plans do not	5c		1		
- Ca				(See instructions.)		Х Үев	No		
				dent qualified public accountant (IC		ж. — — — — — — — — — — — — — — — — — — —	1 140		
_	undor 29 CFR 2520.104-46?	(See Instructions on waiver eligit	filty and condition	ons.)	······	ÿ Yes ☐	No		
				BF and must instand usa Form 55		i i	<u>'</u>		
P;	art III Financial Inform	ation				73			
7	Plan Accord and Liabilities		uuryy	(a) Beginning of Year		(b) End of Year			
а	Total plan assets				0	WE.	538		
b	Total olan liabilities		7b		\neg				
c	the state of the s	75 from line 75)			ol	<u> </u>	538		
<u> </u>	Income, Expanses, and Trans		Judini - Judini	(a) Amount	1	(b) Total			
a				(e) Sinount	+	(b) Total			
-			8a(1)		1	ARRELE TO THE STATE OF THE STAT	J		
	(2) Participants			92	0 .				
		5)			1 7	35			
b	•			(899	27	The state of the s	0. 1 t. 3 tg /		
		, 8a(2), 8a(3), and 8b)		HELT NAMES AND STREET OF THE PARTY OF THE PA	_	42			
d		, ea(2), ea(3), and ep) rollovers and insurance premiur		REPORT OF THE PARTY OF THE PART	(-wt)				
u		rollovers and insurance premiur		(48:	ا ا (د	THE STATE OF THE PARTY OF THE P	,		
A		clive distributions (see instruction				HASSIST TO THE PROPERTY OF THE	Charles Co.		
ş	· ·	ers (salarles, fees, commissions)		(3:	5 J - x '	The second of th	p No. 1		
		•			1.	Market	. 4		
8	•	D- 00 b 0-1		Property of the second	+	Tital	517)		
		, 8e, 6f, and 8g)		1 2 2 2	() _	**************************************	538		
ļ		ne 8h from line 8c)		CAMPAGE CONTRACTOR	-	Market 2 17 Januari I. W. T.			
- 5	ransfers to (from) the plan (:	ee instructions)	111111111111111111111111111111111111111		-	and the same of th	Jan Light College		

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	Form 5500-SF 2009	-	Page 2 -						
Par	t IV Plan Characteristics					7.7			
	If the plan provides ponsion benefits, enter the applicable pension	n feature codes from	the List of Plen Chara	ctorio	tle Co	della in I	the instructi	ions:	
	X 2E 2F 2G 2J 3D					2			
	If the plan provides welfero benefits, enter the applicable wolfare	feature codes from	the List of Plan Chera	cterist	ic Coc	in t	he instructio	ons:	
Part	V Compliance Questions		***************************************						
10	During the plan year:				Yes		/	Amount	
a	29 CFR 2510.3-1027 (See instructions and DOL's Voluntary Fi	duciary Correction P	rogram)	10a					
þ	Were there any nonexempt transactions with any party-in-intere	st? (Do not include t	ransactions reported			虁			
	on line 10a.)			10b					
C	- Was the plan covered by a fidelity bond?			10c					
d	Did the plan have a loss, whether or not reimburged by the plan or dishonesty?			10a		Š.			
0	Word any fees or commissions paid to any brokers, agents, or cinsurance service or other organization that provides some or a instructions.)	ll of the benefits unde	or the pisn? (See	10e	х				9
f	Has the plan falled to provide any benefit when due under the p			10f					
g	Did the plan have any participant loans? (If "Yes," enter amount	as of year end.)	*****	10g					
h	If this is an individual account plan, was there a blackout period	? (See instructions a	nd 29 CFR	109			A STATE OF STATE	************	
	2520.101-3.)			10h				·	
<u>'</u>	If 10h was answered "Yes," check the box if you either provided exceptions to providing the notice applied under 29 CFR 2520.1	the required notice of 01-3	or one of the	101			1,	5 (1) (1) (1) (1) (1) (1) (1) (1)	L <u>.</u> . 0
Part						_ X			
11	Is this a defined benefit plan subject to minimum funding require 5500))	ments? (if "Yes," so	o instructions and com	pleta :	Sched	SB	(Form	Yes	X No
12 .	Is this a defined contribution plan subject to the minimum fundir	ng requirements of se	ection 412 of the Code	OF 30	ction 3	od of E	RISA?	Yes	
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as app	lleable,}				***		_	_
a	If a waiver of the minimum funding standard for a prior year is be granting the waiver.	eing amortized in this	plan year, see instruc	tions,	and g				uling
If :	you completed line 12a, complete lines 3, 9, and 10 of Sched	ule MB (Form 5500)	, and skip to line 13.	ın		, ay		Year	
b	Enter the minimum required contribution for this plan year				Г	4			
¢	Enter the amount contributed by the employer to the plan for this					-	<u> </u>		 -
d	Subtract the amount in line 12c from the amount in line 12b. Ent	er the result (enter a	minus sign to the left of	of a		-			
	negative amount)				<u>L</u>	\$ 1			
	Will the minimum funding amount reported on line 12d be met by		e?				Yes	No	X N/A
Part									
13a	Has a resolution to terminate the plan been adopted during the	olon year or any prior	year?	**	••••• <u>••</u>			Yes	X No
	If "Yes," enter the amount of any plan assets that reverted to the	employer this year							
Ь	Were all the plan assets distributed to participants or beneficiarie of the PRGC2	es, transferred to and	other plan, or brought i	ınder	the co	n dipi		[] V	i XI Nα
c	of the PBGC?	from this plan to and	ither plan(s), identify th	e plar	n(s) lo			∐ Yes	i Xi Nα
1	3c(1) Name of µtan(s).				130	EII	V(s)	13c(3	B) PN(s)
Caut	on: A penalty for the late or incomplete filing of this return/n	aport will be seen	ed uniéss ressansbi	0.021	se le	No.	shed		
Undq SB o	r pondities of perjury and other penallics set forth in the instruction r Schedule MB completed and signed by an annolled actuary, as very little true, corroct, and complete.	ins. I declare that I h	ave examined this retu	rn/rer	ort la	ci dino	if annlicat	ole, a Sci nowledg	olubor e and
SIGI	CHON O ALVA		Marian		11	19/	1/5	1.0	Max
HER		Date			<u>-//</u>	(M)	-11. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ 		11/10/
	/ / // /	. Date	Enter name of in	Z)	الالخراط	28	Pieri somi	estrator	
SIGI			- Choley	<i>/</i>	W	1			
	Signature of emptoyer/plan sponsor	Date	Enter name of∕lh	dividu	ıal sigi	3C (10)	employer o	or plan şı	onsor