	Form 5500-SF	Short Form Annual R	OMB Nos. 1210-0110 1210-0089							
	Department of the Treasury Internal Revenue Service	Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee			e	2010				
Er	Department of Labor mployee Benefits Security Administration	Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).			This Form is Open to Publ					
P	Pension Benefit Guaranty Corporation Complete all entries in accordance with the instructions to the Form 5500-SF.									
		entification Information	2		0/04/	2010				
_	calendar plan year 2010 or fisca	x1			2/31/2					
	This return/report is for:	mployer plan (not multiemployer)	one-participant plan							
В	This return/report is for:	first return/report	n/report							
•		an amended return/report		year return/report (less than 12 mor	· _					
C	C Check box if filing under:									
De	art II - Regio Dien Inform	special extension (enter descriptio	,							
	Art II Basic Plan Inform	nation—enter all requested informa	ation		1b	Three-digit				
	-	ERY ASSOCIATES, P.C. 401(K) PL	AN			plan number 001				
						(PN) ►				
					1c	Effective date of plan 01/01/2005				
	Plan sponsor's name and addre	ess (employer, if for single-employer	plan)		2b	Employer Identification Number (EIN) 20-0590854				
	TROY-SCHENECTADY ROAD				2c	Plan sponsor's telephone number 518-713-5400				
SUIT	E 100 HAM, NY 12110				2d	Business code (see instructions) 621111				
3a	Plan administrator's name and VYORK SPINE & NEUROSURG	address (if same as Plan sponsor, er ERY ASSOCIATES, 1182 TROY-5	nter "Same	;") ΤΑDY ROAD	3b	Administrator's EIN 20-0590854				
P.C.		SUITE 100 LATHAM, NY			3c	Administrator's telephone number 518-713-5400				
4	f the name and/or EIN of the pla	in sponsor has changed since the las	st return/re	port filed for this plan, enter the) EIN					
	name, EIN, and the plan numbe	r from the last return/report. Sponso	r's name		4c	C PN				
5a Total number of participants at the beginning of the plan year					40 5a					
b		the end of the plan year			5a 5b	16				
C	Total number of participants wi	th account balances as of the end of				18				
62	complete this item)	uring the plan year invested in eligibl	o accate?	(Soo instructions)	5c	Yes No				
-	•	le annual examination and report of a		,	PA)					
		See instructions on waiver eligibility a		,		Yes No				
Pa	If you answered "No" to eith	er 6a or 6b, the plan cannot use Fo ation	orm 5500-3	SF and must instead use Form 55	00.					
7	Plan Assets and Liabilities			(a) Beginning of Year		(b) End of Year				
a			7a	744843	3	955714				
b	Total plan liabilities		7b	C)					
C	Net plan assets (subtract line 7	'b from line 7a)	7c	744843	955714					
8	Income, Expenses, and Transf	ers for this Plan Year		(a) Amount		(b) Total				
а	Contributions received or recei		80(1)	54778	3					
			8a(1) 8a(2)	61098	3					
	., .)	8a(3)	C)					
b	.,		8b	107463	3					
С	Total income (add lines 8a(1),	8a(2), 8a(3), and 8b)	8c			223339				
d		ollovers and insurance premiums	8d	3601						
е	· ,	ive distributions (see instructions)	8e	C)					
f		s (salaries, fees, commissions)		8867	-					
g	· · · · · · · · · · · · · · · · · · ·			C	0					
h		3e, 8f, and 8g)	8g 8h			12468				
i		8h from line 8c)	8i			210871				
j	Transfers to (from) the plan (se	e instructions)	8j	C)					

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

Part IV **Plan Characteristics**

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

Part	V	Compliance Questions							
10	Dur	ing the plan year:		Yes	No		Amou	nt	
а		s there a failure to transmit to the plan any participant contributions within the time period described in CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		Х				
b									
С	Wa	as the plan covered by a fidelity bond?	10c	Х				2	200000
d	or d	the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud lishonesty?	10d		Х				
е	insu	re any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, arance service or other organization that provides some or all of the benefits under the plan? (See ructions.)	10e		Х				
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				
h		is is an individual account plan, was there a blackout period? (See instructions and 29 CFR 0.101-3.)	10h		Х				
i		Oh was answered "Yes," check the box if you either provided the required notice or one of the eptions to providing the notice applied under 29 CFR 2520.101-3	10i						
Part	VI	Pension Funding Compliance							
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 0)).						Yes	X No
12									
	(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 date of the letter ruling granting the waiver								
lf	you c	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.		-					
b	Ente	er the minimum required contribution for this plan year			12b 12c				
С	C Enter the amount contributed by the employer to the plan for this plan year								
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left ative amount)		🗋	12d				
е	e Will the minimum funding amount reported on line 12d be met by the funding deadline?							N/A	
Part	VII	Plan Terminations and Transfers of Assets							
13a	a Has a resolution to terminate the plan been adopted during the plan year or any prior year?							× No	
	lf "Y	es," enter the amount of any plan assets that reverted to the employer this year			13a				
b	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.)									
13c(1) Name of plan(s):					c(2) El	N(s)	13	8c(3)	PN(s)
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, 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.	04/22/2011	FRANK L. GENOVESE, MD				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN	Filed with authorized/valid electronic signature.	04/22/2011	FRANK L. GENOVESE, MD				
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor				

Internal Revenue Service 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). 2010 Department of Labor imployee Benefits Security Administration > Complete all entries in accordance with the instructions to the Form 5500-SF. This form is Open to Public Inspection Person Benefits Guaranty Corporation > Complete all entries in accordance with the instructions to the Form 5500-SF. This Form is Open to Public Inspection Person Benefits Guaranty Corporation > Complete all entries in accordance with the instructions to the Form 5500-SF. This Form is Open to Public Inspection Parson Benefits Guaranty Corporation > Complete all entries in accordance with the instructions to the Form 5500-SF. This Form is Open to Public Inspection This return/report is for: \$ single-employer plan multiple-employer plan (not multiemployer) one-participant plan This return/report is for: \$ first return/report \$ an amended return/report \$ one-participant plan Check box if filing under: Form 5558 > automatic extension DFVC program \$ special extension (enter description) \$ of the e-digit plan number ((N)) \$ of 1/01/2005 A Name of plan New York Spine & Neurosurgery Associates, P.C. 401 (k) Plan	Form 5500-SF	Short Form Annual I	/ee	OMB Nos. 1210-011 1210-008						
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Check box if fling under:	This return/report is for:	single-employer plan	multiple-e	mployer plan (not multiemployer)		one-participant plan				
Check box if fing unde:	This return/report is for:	first return/report	final returr	/report						
Special extension (enter description) 24111 Basic Plan Information enter al requested information. Name of plan 1b Three-digit plan number (PN) New York Sprine & Neurosurgery Associates, P.C. 401 (k) Plan 1b Three-digit plan number (PN) New York Sprine & Neurosurgery Associates, P.C. 401 (k) Plan 2b Employer Identification Number (EN) New York Sprine & Neurosurgery Associates, P.C. 401 (k) Plan 2b Employer Identification Number (EN) New York Sprine & Neurosurgery Associates, P.C. 401 (k) Plan 2b Employer Identification Number (EN) New York Sprine & Neurosurgery Associates, P.C. 401 (k) Plan 2b Employer Identification Number (EN) 1328 Tray-Schenectady Road 2c Plan sponsor's telephone number (Sale) 713-5400 2d Business code (see instructions) 531111 Plan administrator's name and address (If same as plan employer, enter "Same") 3b Administrator's Elephone number If the name and/or EN of the plan sponsor has changed since the last return/report field for this plan, enter the name, EN and the plan number (offine dor the plan year) 3c Administrator's Elephone number If the name and/or EN of the plan sponsor has changed since the last return/report field for this plan, enter the name, EN and the plan number (defined benefit plans do not complete his iden waver of the anal exemination and report of an independ to qualified public accurtant (OPA) under 30 CPR 220: 104-d6? (See instructions an eleps of an doutlines, 1)		year return/report (less than 12 mon	lhs)							
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under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Image: Control Contrective Conteroc Contrecontero Control Control Control Control Con					•••	<u>x</u> Yes No				
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					EZON Mike Le					

trol Numbers, see

Form 5500-SF 2010

Plan Characteristics

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

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:

1.15	Compliance Questions							
0	During the plan year:	Yes	No	An	nount			
		0a	x					
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	0ъ	x					
с	Was the plan covered by a fidelity bond?	0c x			200,000			
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud							
	and disharanship	0d	x					
е	Were any fees or commisions paid to any brokers, agents, or other persons by an insurance carrier, insurance services or other organization that provides some or all of the benefits under the plan? (See instructions.)	De	x					
f	Has the plan failed to provide any benefit when due under the plan?	Df	x					
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)		x					
ĥ	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	<u>.</u>						
	2520.101-3.)	Dh	x					
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	Di						
17-25 E	Pension Funding Compliance			Presentation desired and other	Balle Melling Profession - Landson Conference			
1	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete	Schedu	ile SB (Form				
	<u>5500))</u>	•	<u></u>	<u> </u>	Yes X No			
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or se	ction 30	2 of EF	USA?	Yes X No			
	(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 instructions, granting the waiver				er ruling ear			
if y	ou 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	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)	[12d					
e	Will the minimum funding amount reported on line 12d be met by the funding deadline?			Yes	No N/A			
	Plan Terminations and Transfers of Assets							
3a	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						
b	b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?							
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)							
_			3c(2) E	(INI/e)	13c(3) PN(s)			
	3c(1) Name of plan(s):							
		-			•			
autio	n: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable caus	e is est	ablishe	ia				

nder 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 3 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 slief, it is true, coprect, and complete.

K Frank I. Thomson	,	1	/	Frank L. Genovese, MD
	Date 4	119/	T	Enter name of individual signing as plan administrator
* Trank L. X prouse	7	1		Frank L. Genovese, MD
Signature of employer/plan sponsor	Date 4/	19/1	1	Enter name of individual signing as employer or plan sponsor
	-/	7		