## 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 1210-0089

2009

This Form is Open to Public Inspection

					inspection				
Part I Annual Report Identification Information									
For calendar plan year 2009 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007									
A This return/report is for:		a multiemployer plan;	a multiple	e-employer plan; or					
		a single-employer plan;	a DFE (s	pecify)					
<b>B</b> This r	eturn/report is:	the first return/report;	the final r	return/report;					
	·	an amended return/report;	a short p	lan year return/report (less that	an 12 months).				
C If the	plan is a collectively-bargained	plan, check here			□				
	k box if filing under:	Form 5558;	_	c extension;	the DFVC program;				
D Chec	k box ii iiiiiig under.	special extension (enter des		, oxtoriori,	and Dr. ve program,				
Don't l	II Dania Dian Informa	<u> </u>	. ,						
Part I		tion—enter all requested informa	ation		1b Three digitudes				
	ie of plan OWN BRONX MEDICAL ASSO	CAITES P.C 403 B.PI AN			<b>1b</b> Three-digit plan number (PN) ▶ 001	ı			
DOWN	OWN BROWN WEDICAL ASSO	CAITEST C 403 BT LAN			1c Effective date of plan				
					09/01/2000				
		employer, if for a single-employer p	plan)		<b>2b</b> Employer Identification				
,	ress should include room or suit OWN BRONX MEDICAL ASSO	,			Number (EIN) 06-1578286				
DOWNT	OWN BRONX MEDICAL ASSO	CIATES PC			2c Sponsor's telephone				
					number				
234 FAS	T 149TH ST 8D 200	234 FAST	140TH ST 8D 200						
	NY 14643	234 EAST 149TH ST 8D 200 BRONX, NY 14643			2d Business code (see				
				instructions)					
						_			
	· · · · · · · · · · · · · · · · · · ·	mplete filing of this return/repor							
					ncluding accompanying schedules, ef, it is true, correct, and complete.				
SIGN									
HERE	Signature of plan administra	tor	Date	Enter name of individual sign	gning as plan administrator				
					5 <u>5 p</u>				
SIGN									
HERE	Signature of employer/plan s	snonsor	Date	Enter name of individual signing as employer or plan spon-					
	Shataro or omproyon plant		24.0	or name of marriadal sig	giinig ac ciripicyor or plan oponoor				
SIGN									
HERE	Signature of DFF		Date	Enter name of individual sid	nning as DFF				

	Form 5500 (2009)		Pa	ge <b>2</b>	2								
3a Plan administrator's name and address (if same as plan sponsor, enter "Same")  DOWNTOWN BRONX MEDICAL ASSOCIATES PC  234 EAST 149TH ST 8D 200  BRONX, NY 14643						3b Administrator's EIN 06-1578286  3c Administrator's telephone number							
4 a	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:  Sponsor's name	n/repo	t filed for	this	plaı	n, ent	er the	name, E	EIN a	nd	4b E		
5	Total number of participants at the beginning of the plan year									5			
6	Number of participants as of the end of the plan year (welfare plans complete	te only	lines 6a,	6b, (	6с,	and 6	id).			<u> </u>			
а	Active participants								Ī	6a			
b	Retired or separated participants receiving benefits									6b			
C	Other retired or separated participants entitled to future benefits								_	6c			
<b>d</b> Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>								6d					
Deceased participants whose beneficiaries are receiving or are entitled to receive benefits								6e					
,													
f Total. Add lines 6d and 6e								6f					
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)								6g					
h	h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested								6h				
7									7				
8a	If the plan provides pension benefits, enter the applicable pension feature of	odes fr	om the Li	st of	Pla	an Cha	aracte	ristic Co	des i	n the i	nstruct	ions:	
	f the plan provides welfare benefits, enter the applicable welfare feature code											s:	
9a	Plan funding arrangement (check all that apply)  (1) Insurance  (2) Code section 412(e)(3) insurance contracts  (3) Trust  (4) General assets of the sponsor	9b	Plan ben (1) (2) (3) (4)	efit a	In C T	nsurar Code s Trust	nce section	check all n 412(e)( ets of the	(3) ins	suranc		racts	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attache	ed, and, w	here	inc	dicate	d, en	er the nu	umbe	r attac	hed. (	See instru	uctions)
а	Pension Schedules (1) R (Retirement Plan Information)	b	General	Sch	ned	Н		ancial Inf				<b></b> .	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan		(2) (3)		_		`	incial Info irance In			Small F	'lan)	

(4)

(5)

(6)

**C** (Service Provider Information)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(3)

## Form **5500**

Department of the Treasury Internal Revenue Service

Oepartment of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of 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 sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500. Official Use Only OMB Nos. 1210 - 0110 1210 - 0089

2007

This Form is Open to Public Inspection.

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For the calendar plan year 2007 or fiscal plan year	ear beginning	and ending
A This return/report is for: (1) \( \subseteq \ a \text{ multiemploy}	yer plan;	(3) a multiple-employer plan; or
(2) 🗵 a single-emp	loyer plan (other than a	
multiple-emp	loyer plan);	
<b>5</b>		<b>F</b> **1
	n/report filed for the plan	c; (3) the final return/report filed for the plan;
(2) $\coprod$ an amended		(4) La short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, che		·····
D If filing under an extension of time or the DFVC	program, check box an	d attach required information. (see instructions)
Part Basic Plan Information	nter all requested inform	
1a Name of plan		<b>1b</b> Three-digit
DOWNTOWN BRONX MEDICAL ASSOCIA	ATES,	plan number (PN) ► 001
P.C. 403(B) PLAN		1c Effective date of plan (mo., day, yr.)
		09/01/2000
On Discourse		Acceptable of the second of th
2a Plan sponsor's name and address (employer,	if for a single-employer	plan) 2b Employer Identification Number (EIN)
(Address should include room or suite no.)		06-1578286
DOWNTOWN BRONX MEDICAL ASSOCIA	TES,	2c Sponsor's telephone number
P.C.		718-579-6200
		2d Business code (see instructions)
224 FACE 140EU CE OD 000		621112
234 EAST 149TH ST 8D-200		A STATE OF THE PROPERTY OF THE
		(14) 10 10 14 14 14 14 14 14 14 14 14 14 14 14 14
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BRONX	<u>NY</u>	
Linder penalties of porture rate or incomplete tiling of	this return/report will b	e assessed unless reasonable cause is established.
as the electronic version of this refurn/report if it is being filed electronic	nstructions, I declare that I have unically, and to the best of my i	e examined this return/report, including accompanying schedules, statements and attachments, as well mowledge and belief, it is true, correct and complete.
sien // /		, .
arm / / /		
Signature of plan administrator	Date	Type or grint years of individual in
3741	Date	Type or print name of individual signing as plan administrator
in the		
Signature of employer/plan sponsor/DFE	Date	Type or print name of individual signing as employer, plan sponsor or DFE
	ontrol Numbers - cont	the broadless for E
or Paperwork Reduction Act Notice and OMB C		
For Paperwork Reduction Act Notice and OMB Co	ontior numbers, see (	ne instructions for Form 5500. v10.1 Form 5500 (2007)
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or Paperwork Reduction Act Notice and OMB C		

	Form 5500 (2007)	Page <b>2</b>	Official Use Only
<u>З</u> а	Plan administrator's name and address (If same as plan sponsor, enter "Same")	<b>3b</b> Administra	
SA	ME	3c Administra	tor's telephone number
		3C Administra	tor's telephone number
		and the second of the second o	
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,	<b>b</b> EIN
_	EIN and the plan number from the last return/report below:  Sponsor's name		
а	oponisor s name		C PN
5	Preparer information (optional) <b>a</b> Name (including firm name, if applicable) and address		<b>b</b> EIN
			C Telephone number
6	Total number of participants at the beginning of the plan year		6
7	Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c	·	-
a	Active participants		. <u>7a  </u> 7b
D	Other retired or separated participants entitled to future benefits		76 7c
d	Subtotal, Add lines 7a, 7b, and 7c		7d
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		7e
f	Total, Add lines 7d and 7e	<u>.</u>	7f
g	Number of participants with account balances as of the end of the plan year (only defined contribution	,	
_	complete this item)	r	.7g
n	Number of participants that terminated employment during the plan year with accrued benefits that w 100% vested	,	.7h
ì	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated	Г	.7.11
	participants required to be reported on a Schedule SSA (Form 5500)		7i
8	Benefits provided under the plan (complete 8a and 8b as applicable)		_
а	Pension benefits (check this box if the plan provides pension benefits and enter the applicable pen	sion feature codes	s from the List of Plan
<b>L</b>	Characteristics Codes printed in the instructions): 21 2M	ro foaturo codos f	rom the Liet of Dian
Ų	Characteristics Codes printed in the instructions):	le leature codes i	Tom the List of Plan
9a	Plan funding arrangement (check all that apply)  9b Plan benefit arrangement	ment (check all th	at apply)
	(1) Insurance (1) Insurance		
		1 412(i) insurance	contracts
	(3) Trust (4) General assets of the sponsor (4) General assets	ets of the sponsor	
<u>L</u>			

Form 5500 (2007)						age 3					
							Official Use Only				
10	Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)										
а	Pension Benefit Schedules			b	Financial Sche						
	(1)	R	(Retirement Plan Information)		(1)	Н	(Financial Information)				
	(2)	В	(Actuarial Information)		(2)	1	(Financial Information Small Plan)				
	(3)	E	(ESOP Annual Information)		(3) 📙	Α	(Insurance Information)				
	(4)	SSA	(Separated Vested Participant Information)		(4)	С	(Service Provider Information)				
					(5)	D	(DFE/Participating Plan Information)				
					(6)	G	(Financial Transaction Schedules)				
					· ·   🗖						



