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).

2010

OMB Nos. 1210-0110 1210-0089

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

This Form is Open to Public Inspection

For calendar plan year 2010 of riseas plan year beginning OV01/2013 and ending 12/21/2010 A This return/report is for:	Pa	Part I Annual Report Identification Information									
B. This return/report is for: If first return/report Invalor plan year year year year year year year year	For						12/31/2010				
B This return/report is for:	A 1	This return/report is	for:	xingle-employer plan	multiple-	employer plan (not multiemployer)		one-participant plan			
C Check box if filing under:		•		first return/report	final retu						
Part II Basic Plan Information—enter all requested information		·		an amended return/report	short pla	n year return/report (less than 12 mg	onths)				
Part I	C	Check box if filing u	nder:	Form 5558	automati	c extension		DFVC progra	am		
18 Name of plan GRAMATAN UROLOGY, PC PROFIT-SHARING PLAN 29 PIAIN sponsor's name and address (employer, if for single-employer plan) GRAMATAN UROLOGY, PC 29 PIAIN sponsor's name and address (employer, if for single-employer plan) GRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (employer, if for single-employer plan) CRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (employer, if for single-employer plan) CRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (if same as Pian sponsor, enter "Same") CRAMATAN UROLOGY, PC 20 Pian sponsor is telephone number 10 Piain sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 5 Total number of participants at the end of the plan year. 5 Total number of participants at the end of the plan year invested in eligible assets? (See instructions) 6 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 7 Part III Financial Information 7 Pian Assets and Liabilities 7 Part Sponsor		3 .		special extension (enter descri	ption)						
18 Name of plan GRAMATAN UROLOGY, PC PROFIT-SHARING PLAN 29 PIAIN sponsor's name and address (employer, if for single-employer plan) GRAMATAN UROLOGY, PC 29 PIAIN sponsor's name and address (employer, if for single-employer plan) GRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (employer, if for single-employer plan) CRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (employer, if for single-employer plan) CRAMATAN UROLOGY, PC 29 PIAIN Sponsor's name and address (if same as Pian sponsor, enter "Same") CRAMATAN UROLOGY, PC 20 Pian sponsor is telephone number 10 Piain sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 4 If the name and/or EIN of the plan sponsor has changed since the last return/report flield for this plan, enter the name, eith, and the plan number from the last return/report. Sponsor's name 5 Total number of participants at the end of the plan year. 5 Total number of participants at the end of the plan year invested in eligible assets? (See instructions) 6 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 7 Part III Financial Information 7 Pian Assets and Liabilities 7 Part Sponsor	Pa	rt II Basic P	lan Infor	_ `							
Care Plan sponsor's name and address (employer, lif for single-employer plan) Care Effective date of plan 10101/2007 Care Plan sponsor's name and address (employer, lif for single-employer plan) Care Plan sponsor's name and address (employer, lif for single-employer plan) Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's telephone number Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's name and address (lif same as Plan sponsor, enter "Same") Care Plan sponsor's name Ca				onioi an roquotica min			1b	Three-digit			
22 Plan sponsor's name and address (employer, if for single-employer plan) 32 Plan sponsor's name and address (employer, if for single-employer plan) 33 Plan administrator's name and address (if same as Plan sponsor, enter 'Same") 34 Plan administrator's name and address (if same as Plan sponsor, enter 'Same") 35 PONDFIELD ROAD WEST 36 PONDFIELD ROAD WEST 36 PONDFIELD ROAD WEST 37 PONDFIELD ROAD WEST 38 Plan administrator's name and address (if same as Plan sponsor, enter 'Same") 39 Administrator's ElN 30 Administrator's ElN 31 Administrator's ElN 32 Administrator's EleN 33 Administrator's ElN 34 Administrator's ElN 35 Administrator's EleN 36 Administrator's ElN 37 Administrator's ElN 38 Administrator's ElN 38 Administrator's ElN 38 Administrator's ElN 39 Administrator's ElN 30 Administrator's ElN 30 Administrator's ElN 30 Administrator's ElN 31 Administrator's ElN 36 Administrator's ElN 37 Administrator's ElN 38 Administrator's ElN 39 Administrator's ElN 30 Administrator's			, PC PROF	IT-SHARING PLAN				•	003		
2a Plan sponsor's name and address (employer, if for single-employer plan) GRAMATAN UROLOGY, PC 2a PONDFIELD ROAD WEST BRONXVILLE, NY10708 3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") GRAMATAN UROLOGY, PC 2d Business code (see instructions) 22th 17000 3c Administrator's Elink 6d PN 3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") GRAMATAN UROLOGY, PC 2d Business code (see instructions) 22th 17000 3c Administrator's Elink 6d PN 4d If the name and/or Elin of the plan sponsor has changed since the last return/report filed for this plan, enter the name, Elink, and the plan number from the last return/report. Sponsor's name 4d If the name and/or Elin of the plan sponsor has changed since the last return/report filed for this plan, enter the name, Elink, and the plan number from the last return/report. Sponsor's name 4d Elink 4d Pin 5a Total number of participants at the beginning of the plan year 5b Total number of participants at the end of the plan year 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 6d Were all of the plan's assets during the plan year invested in eligible assets? (See instructions) 7e Plan Assets and Liabilities 7e a 3495009 7e 3495009 7e 3495009 7e 34							4 -	` '			
CEIN 13-2858300 2c Plan sponsor's telephone number 914-793-1200 2d Business code (see instructions) 2d Busin								01/01/2	007		
Standard				ess (employer, if for single-emplo	yer plan)			(EIN) 13-2958300			
3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") GRAMATAN UROLOGY, PC BRONXVILLE, NY 10708 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 of participants at the beginning of the plan year 5a Total number of participants at the beginning of the plan year. 5a Total number of participants at the end of the plan year. 5a Total number of participants at the end of the plan year. 5b Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5c 3 3 5b 3 3 5c 3 3 5							2c	Plan sponsor's t 914-79	elephone number 3-1200		
13-2-958300 3c Administrator's telephone number 13-2-958300 3c Administrator's telephone n	DICOI	AXVILLE, INT. 10700	0				2d		see instructions)		
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 4 b EIN 4 c PN 5 a Total number of participants at the beginning of the plan year. 5 a Total number of participants at the end of the plan year. 5 a Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 a Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 6 a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions,). 6 b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) 6 If you answered "No" to either 6 ao r 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. 7 a 3495009 7 a 3495009 7 a 3495009 7 b Total plan assets (subtract line 7b from line 7a). 7 c 3495009 8 a 3654831 8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers. (2) Participants. (3) Others (including rollovers). (3) Others (including rollovers). (4) Elm Asset (a) Amount (b) Total 6 D Other income (loss). (5) Other expenses (add lines 8a(1), 8a(2), 8a(3), and 8b). (6) End of Year (7) Engloyers. (8) Ba(1) (9) Other expenses (add lines 8a(1), 8a(2), 8a(3), and 8b). (8) Ba(1) (1) Engloyers. (9) Other expenses (add lines 8a(1), 8a(2), 8a(3), and 8b). (1) Engloyers. (1) Engloyers. (2) Participants. (3) Others (including direct rollovers and insurance premiums to provide benefits). (8) Other income (loss) (subtract line 8h from line 8c). (8) Other expenses (add lines 8a(1), 8a(2), 8a(3), 8a(3). (1) Engloyers. (2) Participants. (3) Other expenses (add lines 8a(1), 8a(2), 8a(3), 8a(3). (4) Other expenses.	3a GRAM	Plan administrator's MATAN UROLOGY	s name and , PC	26 POND	FIELD ROAD) WEST	3b				
Same EIN, and the plan number from the last return/report. Sponsor's name Same				BRONAV	ILLE, INT 107	08	3с	Administrator's 1	telephone number 3-1200		
Total number of participants at the beginning of the plan year 5a 3 3						eport filed for this plan, enter the	4b	EIN			
b Total number of participants at the end of the plan year	r	name, EIN, and the	plan numbe	er from the last return/report. Spo	nsor's name		4c	PN			
C Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.). 6b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	5a	Total number of pa	articipants a	t the beginning of the plan year			5a		3		
Complete this item) Sc 3	b	Total number of pa	articipants a	t the end of the plan year			5b		3		
Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-467 (See instructions on waiver eligibility and conditions.) If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Part III Financial Information 7 Plan Asset and Liabilities 1 Total plan assets	С	•	•		•	•	5c		3		
under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)		There are a tree plant a deserte during the plant year introduct in englishe deserte. (See included the plant a deserte during the plant year introduct in englishe deserte.)									
Part III Financial Information 7	b	under 29 CFR 252	20.104-46?	(See instructions on waiver eligibil	lity and condi	tions.)			X Yes No		
7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year a Total plan assets 7a 3495009 3654831 b Total plan liabilities 7b 3495009 3654831 c Net plan assets (subtract line 7b from line 7a) 7c 3495009 3654831 8 Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total Contributions received or receivable from:	D				e Form 5500	-SF and must instead use Form 5	500.				
a Total plan assets 7a 3495009 3654831 b Total plan liabilities 7b 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 3495009 3654831 3 3654831 3 3 3654831 3 3 3 3654831 3 3 3 3654831 3				ation			-				
b Total plan liabilities	-						0	(b) End			
Recompliant Recomp		•			_	349300	3		3034031		
8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers		•				349500	9		3654831		
a Contributions received or receivable from: (1) Employers 8a(1) (2) Participants 8a(2) (3) Others (including rollovers) 8a(3) b Other income (loss) 8b 276149 c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8c 276149 d Benefits paid (including direct rollovers and insurance premiums to provide benefits) 8d 116327 e Certain deemed and/or corrective distributions (see instructions) 8e f Administrative service providers (salaries, fees, commissions) 8f g Other expenses 8d 8d lines 8d, 8e, 8f, and 8g) 8h Total expenses (add lines 8d, 8e, 8f, and 8g) 8h 116327 i Net income (loss) (subtract line 8h from line 8c) 8i 159822		•		,	/C			4.5			
(1) Employers 8a(1) (2) Participants 8a(2) (3) Others (including rollovers) 8a(3) b Other income (loss) 8b C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8c C Benefits paid (including direct rollovers and insurance premiums to provide benefits) 8d 6 Certain deemed and/or corrective distributions (see instructions) 8e f Administrative service providers (salaries, fees, commissions) 8f g Other expenses 8g h Total expenses (add lines 8d, 8e, 8f, and 8g) 8h i Net income (loss) (subtract line 8h from line 8c) 8i		•				(a) Amount		(a)	otai		
(3) Others (including rollovers)	_				8a(1)						
b Other income (loss)		(2) Participants			8a(2)						
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		(3) Others (includi	ing rollovers	s)	8a(3)						
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	b	Other income (loss	s)		8b	27614	9				
to provide benefits)	_								276149		
f Administrative service providers (salaries, fees, commissions)		to provide benefits)		8d	11632	7				
g Other expenses 8g h Total expenses (add lines 8d, 8e, 8f, and 8g) 8h 116327 i Net income (loss) (subtract line 8h from line 8c) 8i 159822	е	Certain deemed ar	nd/or correc	tive distributions (see instructions) 8e		_				
h Total expenses (add lines 8d, 8e, 8f, and 8g)	f	Administrative serv	vice provide	rs (salaries, fees, commissions)	8f						
i Net income (loss) (subtract line 8h from line 8c)	g	Other expenses			8g						
i Net intorne (ioss) (subtract line of norm line oc).	h	Total expenses (ad	dd lines 8d,	8e, 8f, and 8g)	8h						
Transfers to (from) the plan (see instructions)	į								159822		
For Department Poduction Act Nation and OMP Control Numbers, con the instructions for Earn 5500 SE	j	, , ,		,	O J						

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Part IV	Dian	(`haract	Orietics
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9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

	in the plant provides wellare benefits, enter the applicable wellare reactive codes from the List of Flan Cha					0.1.01.01	
art	V Compliance Questions						
0	During the plan year:		Yes	No		Amour	ıt
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.)	10b		X			
С	Was the plan covered by a fidelity bond?	10c		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?	10d		X			
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.)	10e		X			
f	Has the plan failed to provide any benefit when due under the plan?	10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X			
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		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	10i					
art	VI Pension Funding Compliance						
1	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and co 5500))					. TY	es X No
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Co	de or se	ection 3	302 of	ERISA?	. N	es ื No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)						
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see inst granting the waiver.	onth					
	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1			40h	I		
	Enter the minimum required contribution for this plan year			12b			
	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 le negative amount)			12d			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No	N/A
art	VII Plan Terminations and Transfers of Assets						
3а	Has a resolution to terminate the plan been adopted during the plan year or any prior year?					Y	es 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 brough of the PBGC?	t under	the co	ntrol		Y	es X No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the pla	n(s) to				
1	3c(1) Name of plan(s):		13	c(2) El	N(s)	130	(3) PN(s)
Cauti	on: A penalty for the late or incomplete filing of this return/report will be assessed unless reason	ble car	ıse is	establ	ished		
Jnde SB or	penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this r Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this retu- it is true, correct, and complete.	eturn/re	port, in	cludin	g, if applic		

SIGN	Filed with authorized/valid electronic signature.	08/09/2011	JOSEPH PUTIGNANO				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN	Filed with authorized/valid electronic signature.	08/09/2011	JOSEPH PUTIGNANO				
HERE	Signature of employer/plan sponsor	Date	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-SE

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

	Part I Annual Report Identification Information	bordanioe wit	n the manacu	ons to the Form 5500	J-3:		
<u> FOI</u>	r the calendar plan year 2010 or fiscal plan year beginning	01/0	1/2010	and ending	12,	/31/2010	
Α	This return/report is for: x single-employer plan	multiple-e	mployer plan (n	ot multiemployer)		one-participant plan	
В	This return/report is for: first return/report	final retur	n/report				
	an amended return/report	short plan	year return/rep	ort (less than 12 month	ıs)		
C	Check box if filing under: X Form 5558	automatic	extension		Г	DFVC program	
	special extension (enter descript	tion)			_	,	
P	art II Basic Plan Information enter all requested in	oformation					
	Name of plan	normation,			1h 1	hree-digit	
	GRAMATAN UROLOGY, PC PROFIT-SHARING PLAN					lan number	
	GREET FAN GROUDGE, FC PROFIL-SHARING PLAN			-		PN) ▶ 003	
						ffective date of plan 1/01/2007	
2a	Plan sponsor's name and address (employer, if for single-employe	r plan)				mployer Identification N	lumber
	GRAMATAN UROLOGY, PC			_	(E	EIN) 13-2958300	
	26 PONDFIELD ROAD WEST					lan sponsor's telephone 914) 793–1200	number
US	BRONXVILLE NY 10708					usiness code (see instr	uctions)
3a	Plan administrator's name and address (If same as plan employer,	enter "Same	")			21111 dministrator's E!N	
	Same		,			anning ator 5 Env	
	•				3c A	dministrator's telephone	number
						amminutator a telephone	Hamber
4	If the name and/or EIN of the plan sponsor has changed since the	last return/ren	ort filed for this	nlan, enter the	4b ∈	INI .	<u></u> sa An ar ii Anii
	name, EIN and the plan number from the last return/report. Sponso	or's Name	ort mod for trild	pian, craci the			
5a	Total number of participants at the beginning of the plan year				4c ₽		
b	Total number of participants at the end of the plan year			· · · · · · ·	5a 5b		<u>3</u>
Ç	Total number of participants with account balances as of the end o	f the plan vea	r (defined benef	it plans do not	UU		
Sa	complete this item)				5c		3
b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of	le assets? (Se an independe	e instructions.)	in accountant (IODA)	• •	<u>X</u> Ye	sNo
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a	and conditions	.)				s \square No
10.11(0)K	If you answered "No" to either 6a or 6b, the plan cannot use Fo	orm 5500-SF	and must inste	ad use Form 5500.		_	
Pa	nt III Financial Information						
7	Plan Assets and Liabilities		(a) Be	ginning of Year		(b) End of Year	
	Total plan assets	. 7a		3,495,009		3,65	4,831
b	Total plan liabilities ,	. 7b					
C	Net plan assets (subtract line 7b from line 7a)	7c		3,495,009	ļ	3,65	4,831
} -	Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total	
а	Contributions received or receivable from: (1) Employers	. 8a(1)					
	(2) Participants	. 8a(2)			1		
	(3) Others (including rollovers)	. 8a(3)					
b	Other income (loss)	. 8b		276,149			
C	Total income(add lines 8a(1), 8a(2), 8a(3), and 8b)	. 8c			The same of the sa	270	6,149
d	Benefits paid (including direct rollovers and insurance premiums						,,
_	to provide benefits)	. <u>8d</u>		116,327			
e f	Certain deemed and/or corrective distributions (see instructions) .	· 8e	<u> </u>				
g	Administrative service providers (salaries, fees, commissions) Other expenses	. 8f					
o h		· 8g					
. <i>.</i> i	Total expenses (add lines 8d, 8e, 8f, and 8g)	- 8h					5,327
i	Net income (loss) (subtract line 8h from line 8c)	• 8i				159	9,822
	Transions to (norm) the plant (see instructions)	. 8j			I SYSTEM		

Service State of	100/05/2020		· · · · · · · · · · · · · · · · · · ·							
Par	IV Plan Characteristics									
9a	a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2A 2E 3D									
b	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:									
Par	Compliance Questions									
10	During the plan year:			Yes	No	An	nount			
a	Was there a failure to transmit to the plan any participant contribution	within the time perior	d described in		×					
l.	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary	Correction Program	, –	0a						
b	Were there any nonexempt transactions with any party-in-interest? (Don line 10a.)	0Ь	х							
C	Was the plan covered by a fidelity bond?		1	0c	x					
d	Did the plan have a loss, whether or not reimbursed by the plan's fide or dishonesty?	•	* I	0d	x					
е	Were any fees or commissions paid to any brokers, agents, or other prinsurance services or other organization that provides some or all of tinstructions.)	he benefits under the	plan? (See	0e	x					
f	Has the plan failed to provide any benefit when due under the plan?			Of	х	•				
g	Did the plan have any participant loans? (If "Yes," enter amount as of	year end.)		0g	х					
ĥ	If this is an individual account plan, was there a blackout period? (Sec 2520.101-3.)	e instructions and 29	CFR	Ť	х					
i	If 10h was answered "Yes," check the box if you either provided the reexceptions to providing the notice applied under 29 CFR 2520.101-3	equired notice or one	of the							
Par	VI Pension Funding Compliance			 '	 					
11	Is this a defined benefit plan subject to minimum funding requirement 5500))	s? (If "Yes," see instr	uctions and complete	Schedu	ile SB (I	Form	Yes X No			
12	Is this a defined contribution plan subject to the minimum funding req (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable	uirements of section								
a	If a waiver of the minimum funding standard for a prior year is being a granting the waiver		Month							
b	Enter the minimum required contribution for this plan year	•	-	Γ	12b					
C	Enter the amount contributed by the employer to the plan for this plan				12c					
d	Subtract the amount in line 12c from the amount in line 12b. Enter the negative amount)	e result (enter a minu	s sign to the left of a		12d					
е	Will the minimum funding amount reported on line 12d be met by the					Yes [No N/A			
Part		randing deadine:			•					
	Has a resolution to terminate the plan been adopted during the plan y	year or any prior year	>				Yes X No			
	If "Yes," enter the amount of any plan assets that reverted to the emp			[13a	<u> </u>				
h				the con						
c	b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?									
	13c(1) Name of plan(s): 13c(2) EIN(s) 13c(3) PN(s)									
Cauti	on: A penalty for the late or incomplete filing of this return/report w	vill be assessed unle	ess reasonable caus	e is est	ablishe	d.				
SB or	penalties of perjury and other penalties set forth in the instructions, it do Schedule MB completed and signed by an enrolled actuary, as well as it is true, correct, and complete.									
	(A) Us-	cd= 12.	JOSEPH PUTIGNA	ANO						
SIG		Date	Enter name of indivi		ning as	nlan administ	rator			
		01 1			mig as	pran aummist	iatui			
SIG			JOSEPH PUTIGNA							
HE	Signature of mployer/plan sponsor/	Date	Enter name of indivi	dual sigi	ning as	employer or p	lan sponsor			

Page **2-**

Form 5500-SF 2010

5500-SF Electronic Filing Authorization

Plan Name: GRAMATAN UROLOGY, PC PROFIT-SHARING PLAN

EIN/PN: 13-2958300/003

Plan Year: 01/01/2010 - 12/31/2010

I hereby authorize O. A. PENSION SERVICES, INC. to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500-SF for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator

an) The following

Plan Sponsor

(sign)

(date)