#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

SIGN HERE Signature of employer/plan sponsor

Signature of DFE

## 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

2010

This Form is Open to Public Inspection

						Inspection			
Part I	An	nual Report Iden	tification Information						
For cale	For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010								
A This return/report is for: a multiemployer plan; a multiple-employer plan; or									
			a single-employer plan;	a DFE (	specify)				
				<u> —</u>					
<b>B</b> This	return/re	eport is:	the first return/report;	the final	return/report;				
			an amended return/report;	a short	olan year return/report (less th	an 12 months).			
C If the	plan is	a collectively-bargaine	d plan, check here						
<b>D</b> Chec	ck box if	filing under:	X Form 5558;	automa	tic extension;	the DFVC program;			
		3	special extension (enter des	scription)					
Part	II E	Basic Plan Inform	nation—enter all requested informa	ation					
1a Nan						<b>1b</b> Three-digit plan 001			
MICHAE	EL A. LE	ETTRICK, MD, PC SAF	FEHARBOR 401(K) PROFIT SHARII	NG PLAN		number (PN)			
	1c Effective date of plan 01/01/2001								
2a Plan sponsor's name and address (employer, if for a single-employer plan)       2b Employer Identification									
(Address should include room or suite no.)  MICHAEL A. LETTRICK, MD, PC						Number (EIN) 14-1823167			
MICHAE	EL A. LE	TIRICK, MID, PC				2c Sponsor's telephone			
						number			
1528 CC	OLLIMBI	A TURNPIKE	1529 COL	_UMBIA TURNPIKE		518-477-1191			
		Y 12033		TON, NY 12033-958		2d Business code (see			
						instructions) 621111			
						021111			
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.									
			enalties set forth in the instructions,						
stateme	nts and	attachments, as well a	s the electronic version of this return	n/report, and to the	best of my knowledge and beli	ef, it is true, correct, and complete.			
	L					_			
SIGN HERE	Filed w	ith authorized/valid ele	ctronic signature.	10/01/2011	MICHAEL A LETTRICK MI	)			
	Signa	ature of plan administ	rator	Date	Enter name of individual sign	gning as plan administrator			
O.O.V					MOUNT	_			
SIGN	IFiled w	ith authorized/valid ele	etronic cianaturo	10/01/2011	MICHAEL A LETTRICK M				

Date

Date

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2010) Page **2** 

	Plan administrator's name and address (if same as plan sponsor, enter "San	ne")	1	ministrator's EIN
MI	CHAEL A. LETTRICK, MD, PC			1823167
	28 COLUMBIA TURNPIKE STLETON, NY 12033		nu	ministrator's telephone mber 3-477-1191
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	8
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).		
а	Active participants		. 6a	8
b	Retired or separated participants receiving benefits		6b	0
С	Other retired or separated participants entitled to future benefits		. 6c	2
d	Subtotal. Add lines 6a, 6b, and 6c		. 6d	10
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e	0
f	Total. Add lines 6d and 6e		. 6f	10
g	Number of participants with account balances as of the end of the plan year complete this item)	•	. 6g	10
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	0
7	Enter the total number of employers obligated to contribute to the plan (only		7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristic Code	s in the i	nstructions:
	2E 2H 2J 3D  f the plan provides welfare benefits, enter the applicable welfare feature code			
Эа	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	ат арріу)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurand	e contracts
	(3) Trust (4) General assets of the sponsor	(3) X Trust (4) General assets of the specific control	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a			hed. (See instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) X I (Financial Inform		Small Plan)
	actuary	(3) X A (Insurance Infor C (Service Provide	,	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participati		,
	Information) - signed by the plan actuary	(6) G (Financial Trans	-	

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2010

					Inspection		
For calendar plan year 20°	10 or fiscal pla	an year beginning 01/01/2010		and er	iding 1	2/31/2010	•
A Name of plan MICHAEL A. LETTRICK, MD, PC SAFEHARBOR 401(K) PROFIT SHARING PLAN  B Three-digit plan number (PN)						PN) •	001
C Plan sponsor's name a MICHAEL A. LETTRICK,		ne 2a of Form 5500.		<b>D</b> Employ 14-182		ication Number (I	EIN)
on a separat		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f	From	<b>(g)</b> To
31-4156830	66869	0000MICH01NY001		8 01/01/2010		010	12/31/2010
2 Insurance fee and compute descending order of the		nation. Enter the total fees and to	tal commissions paid. L	ist in item 3	the agent	s, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
0							
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all	persons).			
	(a) Name	and address of the agent, broker	, or other person to who	m commissi	ons or fee	s were paid	
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broker	or other person to who	m commissi	ons or fee	s were paid	
	(a)	and dad oct of the agon, pronor	, 6. 6 posec., 10		<u> </u>	о ного раза	
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	•		(e) Organization code

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Face and other commission	an noid				
(b) Amount of sales and base commissions paid	Fees and other commissions paid  (c) Amount  (d) Purpose			(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	idual contracts with each carrier ma	ay be treated as a uni	t for purposes of
_		this report.	<u>.</u>	1 4	
		ent value of plan's interest under this contract in the general account at year			423870
_		ent value of plan's interest under this contract in separate accounts at year en	nd	5	423070
b	Contr	racts With Allocated Funds:  State the basis of premium rates  AS PUBLISHED/FILED BY INSURANCE  AS PUBLISHED BY INSURANCE	CE CO		
	а	State the basis of premium rates	02 00		
				01	21780
		Premiums paid to carrier		6b	
		Premiums due but unpaid at the end of the year		6c	0
		If the carrier, service, or other organization incurred any specific costs in cor		6d	653
		retention of the contract or policy, enter amount  Specify nature of costs  CONTRACT COMMISSIONS			
		Specify nature of costs			
	е	Type of contract: (1) $\stackrel{\times}{\square}$ individual policies (2) $\stackrel{\square}{\square}$ group deferred	d annuity		
		(3) other (specify)			
		<del>-</del>			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check here		
7		racts With Unallocated Funds (Do not include portions of these contracts ma			_
•			ate participation guarantee		
	а				
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(C)Total additions		7c(6)	
	_	(6)Total additions		7c(0)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> ).		/u	
		Deductions:	7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account			
	(	(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			

Page	4

Schedule A (Form	เ ออบบ	) ZUTU
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Pa	art II						
		If more than one contract covers the same ginformation may be combined for reporting p the entire group of such individual contracts.	urposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а「	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unem	ployment	h Prescription drug
	ιĖ	Stop loss (large deductible)	j HMO contract	, J_ k□	PPO contract	, ,	I Indemnity contract
	m	=	,	L			
9	Evne	erience-rated contracts:					
•	•	Premiums: (1) Amount received		9a(1)			
	٠.	(2) Increase (decrease) in amount due but unpair		9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		-1 σα( . /	
	-	(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c		•••••		. <del> </del>	
	·	(A) Commissions	, ,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	•			9c(1)(H	
		(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1					
	u	(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n				9e	
10		nexperience-rated contracts:	ot molade amount entered	· · · · · · · · · · · · · · · · · · ·		1 30	
•		Total premiums or subscription charges paid to	arrier			. 10a	
	b	If the carrier, service, or other organization incur				104	
		retention of the contract or policy, other than rep	, .		•	. 10b	
	Sp	ecify nature of costs					

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

**Provision of Information** 

Part IV

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2010

nursuant to EDICA continu (102/a)/2)						m is Open to Public Inspection	
For calendar plan year 20	10 or fiscal pla	an year beginning 01/01/2010	)	and er	nding 12/31/2010		
A Name of plan MICHAEL A. LETTRICK,	MD, PC SAFE	EHARBOR 401(K) PROFIT SHA	RING PLAN		e-digit number (PN)	001	
C Plan sponsor's name a MICHAEL A. LETTRICK,		ne 2a of Form 5500.		<b>D</b> Emplo 14-182	yer Identification Number 23167	(EIN)	
on a separat		ning Insurance Contract  Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		IPANY					
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or c	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
31-4156830	66869	0000LETT00NY00S		8 01/01/2010		12/31/2010	
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in item 3	the agents, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ions or fees were paid		
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose			
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ions or fees were paid		
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code	

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Face and other commission	an noid				
(b) Amount of sales and base commissions paid	Fees and other commissions paid  (c) Amount  (d) Purpose			(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			

Pá	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrier m	ay be treated as	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	0
5	Curr	ent value of plan's interest under this contract in separate accounts at year en	nd		5	53537
6	Cont	racts With Allocated Funds:				
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CC	)			
	b	Premiums paid to carrier			6b	1034
	C	Premiums due but unpaid at the end of the year				0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	41
		Specify nature of costs CONTRACT COMMISSIONS			···· <u>l</u>	
	e	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶				
	t	If contract purchased, in whole or in part, to distribute benefits from a termin		<u> </u>		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma		. ,		
	а	Type of contract: (1) deposit administration (2) immedia	ite participat	ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
	е	Deductions:	- 41			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	

**7**f

f Balance at the end of the current year (subtract e(5) from d).....

Page	4

Schedule A (Form	เ ออบบ	) ZUTU
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Pa	art II						
		If more than one contract covers the same ginformation may be combined for reporting p the entire group of such individual contracts.	urposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а「	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unem	ployment	h Prescription drug
	ιĖ	Stop loss (large deductible)	j HMO contract	, J_ k□	PPO contract	, ,	I Indemnity contract
	m	=	,	L			
9	Evne	erience-rated contracts:					
•	•	Premiums: (1) Amount received		9a(1)			
	٠.	(2) Increase (decrease) in amount due but unpair		9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		-1 σα( . /	
	-	(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c		•••••		. <del> </del>	
	·	(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	•			9c(1)(H	
		(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1					
	u	(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n				9e	
10		nexperience-rated contracts:	ot molade amount entered	· · · · · · · · · · · · · · · · · · ·		1 30	
•		Total premiums or subscription charges paid to	arrier			. 10a	
	b	If the carrier, service, or other organization incur				104	
		retention of the contract or policy, other than rep	, .		•	. 10b	
	Sp	ecify nature of costs					

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

**Provision of Information** 

Part IV

### **SCHEDULE I** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public

Pension Benefit Guaranty Corporation	, inducting an accomment to		Inspection		
For calendar plan year 2010 or fiscal pla	an year beginning 01/01/2010		and ending 12	/31/2010	
A Name of plan MICHAEL A. LETTRICK, MD, PC SAFEI	HARBOR 401(K) PROFIT SHARING PLAN	В	Three-digit plan number (PN)	<b>•</b>	001
C Plan sponsor's name as shown on lin MICHAEL A. LETTRICK, MD, PC	ne 2a of Form 5500	D	Employer Identificati 14-1823167	on Numbe	er (EIN)

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

#### **Small Plan Financial Information**

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

1	Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
а	Total plan assets	. 1a	394681	501629
b	Total plan liabilities	. 1b	0	
С	Net plan assets (subtract line 1b from line 1a)	1c	394681	501629
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	<b>(b)</b> Total
а	Contributions received or receivable:			
	(1) Employers	2a(1)	11122	
	(2) Participants	. 2a(2)	34880	
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	. 2b		
С	Other income	. 2c	64936	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	. 2d		110938
е	Benefits paid (including direct rollovers)	. 2e	3750	
f	Corrective distributions (see instructions)	. 2f	0	
g	Certain deemed distributions of participant loans (see instructions)	. 2g	0	
h	Administrative service providers (salaries, fees, and commissions).	. 2h	0	
i	Other expenses	. 2i	240	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		3990
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		106948
	Transfers to (from) the plan (see instructions)	. 2I		

Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a lineby-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
а	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	
	Real estate (other than employer real property)			X	
d	Employer securities	3d		X	
е	Participant loans	3e		X	

	Schedule I (Form 5500) 2010 Page <b>2-</b>		· ·	_	
			Yes	No	Amount
f	Loans (other than to participants)	3f		X	
j	Tangible personal property	3g		X	
<b>⊃</b> a	rt II Compliance Questions				
	During the plan year:		Yes	No	Amount
	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		Х	
	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance	4b		X	
	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
<del>)</del>	Was the plan covered by a fidelity bond?	4e	X		500
	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		Х	
_	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
	Has the plan failed to provide any benefit when due under the plan?	41		X	
n	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

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.)

5b(2) EIN(s)

5b(3) P

5b(1) Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> PN(s)

## SCHEDULE R (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Retirement Plan Information**

This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For	r calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and e	ending	12/31	/2010			
	Name of plan HAEL A. LETTRICK, MD, PC SAFEHARBOR 401(K) PROFIT SHARING PLAN	В	Three-dig plan num (PN)			001	
	Plan sponsor's name as shown on line 2a of Form 5500 HAEL A. LETTRICK, MD, PC	D	Employer	Identific	ation Numb	er (EIN	I)
IVIICI	TIALL A. LETTRICK, MID, FO		14-1823	3167			
_	ALL DIVINIO						
	art I Distributions references to distributions relate only to payments of benefits during the plan year.						
1	Total value of distributions paid in property other than in cash or the forms of property specified in the						
	instructions		1				
2	Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries duri payors who paid the greatest dollar amounts of benefits):	ing the	year (if m	ore than	two, enter	EINs	f the two
	EIN(s): 31-4156830						
	Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.						
3	Number of participants (living or deceased) whose benefits were distributed in a single sum, during the year.		3				
P	Part II Funding Information (If the plan is not subject to the minimum funding requirements of			of the In	ternal Rev	enue C	nde or
	ERISA section 302, skip this Part)	01 00011	011 01 412	01 1110 111	tomai rtov	criac o	Juc 01
4	Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?			Yes		No	N/A
	If the plan is a defined benefit plan, go to line 8.						
5	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 ruling letter granting the waiver.  Date: Mon	nth		Day		Year	
				-			
	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the rei	maind	er of this	schedul	le.		
6	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the rerative at Enter the minimum required contribution for this plan year				le.		
6			6a	ı	le.		
6	a Enter the minimum required contribution for this plan year		6a	)	le.		
6	<ul> <li>a Enter the minimum required contribution for this plan year</li></ul>		6a	)	le.		
<b>6</b>	<ul> <li>a Enter the minimum required contribution for this plan year</li></ul>		6a	)		No	□ N/A
	<ul> <li>a Enter the minimum required contribution for this plan year</li></ul>	viding	6a	Yes			
7	a Enter the minimum required contribution for this plan year	viding	6a			No No	□ N/A
7 8	a Enter the minimum required contribution for this plan year	viding	6a	Yes			
7 8	a Enter the minimum required contribution for this plan year	viding	6a	Yes			
7 8	a Enter the minimum required contribution for this plan year	viding	6a 6b 6c 6c	Yes		No	
7 8 Pa	a Enter the minimum required contribution for this plan year	viding agree	6a 6b 6c 6c 6c	Yes	Bot	No h	□ N/A
7 8 Pa	b Enter the minimum required contribution for this plan year	viding agree	6a 6b 6c	Yes Yes	Bot	No h	□ N/A
7 8 Pa	b Enter the minimum required contribution for this plan year	viding agree	6a 6b 6c	Yes Yes Crease nal Reve	Botenue Code,	No h	□ N/A
7 8 Pa 9	a Enter the minimum required contribution for this plan year	viding agree  ease (e)(7) c ay any	6a 6b 6c [   Dec of the Inter exempt lo	Yes Yes Trease Trease Trease Trease Trease Trease Trease Trease	Botenue Code,	No h	N/A No

Page <b>2</b> ·
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Schedule R (Form 5500) 2010

Par	t V	Additional Information for Multiemployer Defined Benefit Pension Plans									
13	Ente	er the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in									
		lollars). See instructions. Complete as many entries as needed to report all applicable employers.									
	a	Name of contributing employer									
	b	EIN C Dollar amount contributed by employer									
	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year									
	е	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)									
		(1) Contribution rate (in dollars and cents)									
	a	Name of contributing employer									
	b	EIN C Dollar amount contributed by employer									
	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year									
	е	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)  (2) Base unit measure: Hourly Weekly Unit of production Other (specify):									
	a	Name of contributing employer									
	b	EIN C Dollar amount contributed by employer									
	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year									
	е	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)  (2) Base unit measure: Hourly Weekly Unit of production Other (specify):									
	a	Name of contributing employer									
	b b	EIN C Dollar amount contributed by employer									
,	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year									
1	е	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)  (2) Base unit measure: Hourly Weekly Unit of production Other (specify):									
	<b>a</b>	Name of contributing amplayor									
	a b	Name of contributing employer  EIN  C Dollar amount contributed by employer									
	<u>บ</u> d										
		Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year									
	е	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)  (2) Base unit measure: Hourly Weekly Unit of production Other (specify):									
	_	No. 10 of the state of the stat									
	a b	Name of contributing employer  EIN C Dollar amount contributed by employer									
	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box									
,	e	and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year  Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)									

Page .
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14	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of participant for:	the	
	a The current year	14a	
	<b>b</b> The plan year immediately preceding the current plan year	14b	
	C The second preceding plan year	14c	
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to makemployer contribution during the current plan year to:	ke an	
	a The corresponding number for the plan year immediately preceding the current plan year	15a	
	<b>b</b> The corresponding number for the second preceding plan year	15b	
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:		
	a Enter the number of employers who withdrew during the preceding plan year	16a	
	<b>b</b> If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, ch supplemental information to be included as an attachment.		
P	art VI Additional Information for Single-Employer and Multiemployer Defined Benefi	t Pens	ion Plans
18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole of and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instruction to be included as an attachment	struction	s regarding supplemental
19	If the total number of participants is 1,000 or more, complete items (a) through (c)		
	Enter the percentage of plan assets held as: Stock:% Investment-Grade Debt:% High-Yield Debt:% Real Estate:  B Provide the average duration of the combined investment-grade and high-yield debt: 0-3 years 0-3 6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-2  C What duration measure was used to calculate item 19(b)?		
	Effective duration Macaulay duration Modified duration Other (specify):		

### 5500 Electronic Filing Authorization

Plan Name:

MICHAEL A. LETTRICK, MD, PC SafeHarbor 401(k) Profit Sharing Plan

EIN/PN:

14-1823167/001

Plan Year:

01/01/2010 - 12/31/2010

I hereby authorize Anthony S. Asterino, CPA to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 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

(sign)

(date)

Plan Sponsor

{sian

1-1-1-1

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#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Emptoyee 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

2010

This Form is Open to Public Inspection

Part I Annual Report	Identification Information					
For the calendar plan year 201	10 or fiscal plan year beginning 01	/01/2010	and ending 12/31,			
A This return/report is for:	a multiemployer plan;		a multiple-employer p	lan; or		
	x a single-employer plan;		a DFE (specify)			
B This return/report is:	the first return/report;		the final return/report;			
B This returnineport is.	an amended return/report;		a short plan year retu	m/report (less than 12 months).		
C If the plan is a collectively-bar				▶□		
D Check box if filing under:	Form 5558;		automatic extension;	the DFVC program;		
D Check box is many direct.	special extension (enter descripti	on)		<del>_</del>		
Emissions Deale Dies Infe	ormation enter all requested in					
	ormation enter all requested to	morniauon.	<u> </u>	1b Three-digit plan		
1a Name of plan	CK, MD, PC SafeHarbor 401()	. Profit Shari	ng Plan	number (PN) ► 001		
MICHAEL A. LETTRIC	CK, MD, PC Salenarbor 401()	c, riorre budra		1c Effective date of plan		
				01/01/2001		
2a Plan sponsor's name and	address (employer, if for a single-emplo	over plan)	· · · · · · · · · · · · · · · · · · ·	2b Employer Identification		
(Address should include ro		, <b>, .</b> ,		Number (EIN)		
•				14-1823167		
MICHAEL A. LETTRIC	CK, MD, PC			2c Sponsor's telephone		
				number		
				(518) 477-1191		
1528 COLUMBIA TUR	NPIKE			2d Business code (see		
1320 00101221 1010				instructions)		
US CASTLETON	พұ 12033			621111		
05 04222301						
Caution: A penalty for the late	or incomplete filling of this return/rep	ort will be assessed	uniess reasonable cause is	established.		
	ther penalties set forth in the instruction	a I doctore that I have	evamined this return/renort i	including accompanying schedules.		
	20	1-1-1				
SIGN	Horolo	715111	MICHAEL A. LETTRIC	K, MD		
HERE OUT	administrator	Date	Enter name of individual sig	ning as plan administrator		
Signature of plan	Yn II.	7/1-1				
SIGN	Stroke	1/5/1/	MICHAEL A. LETTRIC	K, MD		
HERE Signature of emph	oyer/plan sponsor	Date	Enter name of individual sig	gning as employer or plan sponsor		
SIGN						
HERE		Date	Enter name of individual sign	gning as DFE		
Signature of DFE				F FF00 (2040)		

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 За	Plan administrator's name and address (if same as plan sponsor, enter "Sa	ıme")				3b /	Administrator's EIN
	Same .						Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	m/repo	rt filed	for	this plan, enter the name, EIN	and	4b EIN
а	Sponsor's name						4c PN
5	Total number of participants at the beginning of the plan year	• •				5	8
6	Number of participants as of the end of the plan year (welfare plans comple					SWE	
а	Active participants					6a	8
b	Retired or separated participants receiving benefits					6b	0
С	Other retired or separated participants entitled to future benefits					6c	2
d	Subtotal. Add lines 6a, 6b and 6c					6d	10
e	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive	benef	its		6e	0
f	Total. Add lines 6d and 6e					6f	10
g	Number of participants with account balances as of the end of the plan year complete this item)	r (only	define • •	d c	ontribution plans	6g	10
h 	Number of participants that terminated employment during the plan year with 100% vested					6h	0
7	Enter the total number of employers obligated to contribute to the plan (onli					7	
8a	If the plan provides pension benefits, enter the applicable pension feature	codes	from t	he	List of Plan Characteristic Code	es in tl	ne instructions:
	2E 2H 2J 3D						
t	If the plan provides welfare benefits, enter the applicable welfare feature of	odes fi	rom th	e L	ist of Plan Characteristic Codes	s in the	e instructions:
_		l at	D:			-4.	1.3
9a	Plan funding arrangement (check all that apply)  (1)   Insurance	9b		De De	nefit arrangement (check all that Insurance	ат арр	iy)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	1	(1) (2)	Ħ	Code section 412(e)(3) insurar	nce co	entracts
	(3) X Trust		(3)	x	Trust		
	(4) General assets of the sponsor		(4)	П	General assets of the sponsor	7	
10		e attact	ned, a	nd,	•		ttached. (See instructions)
а	Pension Schedules	b	Gen	era	I Schedules		
	(1) R (Retirement Plan Information)		(1)	П	H (Financial Informa	ation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	X	I (Financial Informa		Smail Plan)
	Purchase Plan Actuarial Information) - signed by the plan		(3)	x	2 A (Insurance Inform		•
	actuary		(4)		C (Service Provider	Infor	nation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(5)	П	D (DFE/Participating	g Plan	Information)
	Information) - signed by the plan actuary		(6)	Ш	G (Financial Transa	action I	nformation)

Form 5500 (2010)

Page 2

#### **Sponsor Location Information**

Sponsor name:

MICHAEL A. LETTRICK, MD, PC

Sponsor DBA name: Sponsor care of name:

1528 Columbia Turnpike

US Castleton

NY 12033-9584

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

► File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 201	or fiscal pla	an year beginning 01/01/2	2010	and ending	12/31/2010		
A Name of plan				B Three-di			
				plan nun	nber (PN)	001	
AICHAEL A. LETTRICK	MD, PC	SafeHarbor 401(k) Pro	ofit Sharing Pl				
C Plan sponsor's name a	s shown on l	line 2a of Form 5500.		D Employe	er Indentification Numbe	r (EIN)	
MICHAEL A. LETTRICK	MD, PC				14-1823167		
		ning Insurance Contra					
on a separate S	chedule A. I	ndividual contracts grouped as	a unit in Parts II and III	can be report	ted on a single Schedule	э А.	
1 Coverage Information:							
(a) Name of insurance carr	er						
NATIONWIDE LIFE INS	JRANCE CO	MPANY					
	(c) NAIC	1	(e) Approximate	number of	Polic	y or contract year	
(b) EIN	code	(d) Contract or identification number	persons covere policy or cent		(f) From	(g) To	
31-4156830	66869	0000LETT00NY00S		8	1/1/2010	12/31/2010	
2 Insurance fee and com	mission info	rmation. Enter the total fees and	d total commissions pai	d. List in item	3 the agents, brokers, a	and other persons in	
descending order of the	amount pa	id.			•	·	
(a) Total	amount of co	ommissions paid		<b>(b)</b> Tota	al amount of fees paid		
		0			0		
3 Persons receiving com	missions and	d fees. (Complete as many entr	ies as needed to report	all persons).			
	<b>(a)</b> Name a	nd address of the agent, broke	r, or other person to wh	om commissi	ons or fees were paid	···	
(b) Amount of sales a	nd base	Fe	es and other commissi	ons paid			
commissions pa		(C) Amount		(d) Purpose	)	(e) Organization code	
iska populari esperimenta promiti de la		iwscang ngabitanganalikang gyakanga gabat in		aranteritania		Markar Caraca i samuni, massaka nyikijoo ee	
	(a) Name a	nd address of the agent, broke	r, or other person to wh	om commissi	ons or lees were paid		
(b) Amount of sales a	nd base		ees and other commissi				
commissions pa		(C) Amount		(d) Purpose	•	(e) Organization code	
						•	

Schedule A (Form 5500) 2010		Page 2-	
(a) Name	and address of the agent, bro	ker or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
EXPRINTE THE STATE OF THE STATE	entidopos por installado de la compositiva de la compositiva de la compositiva de la compositiva de la composi	perturbation to explore the first three the property of the first three property and the property of the prope	
(a) Name	and address of the agent, bro	oker or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
THE PROPERTY OF THE PROPERTY O			
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Committee of College and Indiana of State	TO SENSO AND THE PROPERTY OF T	and the state of t	
	e and address of the agent, bro	oker or other person to whom commissions or fees were pa	aid
	<del></del>	Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
COMMISSIONS PAID	(O) Fundan	(5). (1,5550	1-,,
		narrinianiem kilotopalisiasi, 133 m. 1165, roma 1455, roma 1455, roma 1455, roma 1455, roma 1455, roma 1455, r	
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were p	aio
(b) Amount of sales and base		Fees and other commissions paid	<del></del>
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

Pá	Investment and Annuity Contract Information		······································
	Where individual contracts are provided, the entire group of such individual contracts with each carrier r this report.	nay be treated	d as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at year end	. 4	0
5	Current value of plan's interest under this contract in separate accounts at year end	. 5	53,537
6	Contracts With Allocated Funds:  a State the basis of premium rates ►  NOT PROVIDED BY INSURANCE CO		
	b Premiums paid to carrier	6b	1,034
	C Premiums due but unpaid at the end of the year	6c	0
	d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	. 6d	41
	Specify nature of costs 🕨		
	CONTRACT COMMISSIONS		
	e Type of contract (1) k individual policies (2) group deferred annuity		
	(3) ☐ other (specify) ►		
	f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	<b>▶</b> ∏	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		<del></del>
ε	a Type on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee		
	(3) ☐ guaranteed investment (4) ☐ other ▶		
	(*) <b>[</b>		
	<b>b</b> Balance at the end of the previous year	. 7b	polic Name of the state of the
(	C Additions: (1) Contributions deposited during the year		
	(2) Dividends and credits		
	(3) Interest credited during the year		
	(4) Transferred from separate account		
	(5) Other (specify below)		
		28/2/1/2002/	
	(6) Total additions	. <u>7c(6)</u>	
	d Total of balance and additions (add b and c(6))	· <u>7d</u>	
•	Deductions:      Disharmed from found to any base file or a number of services during years.  7-(1)	推集。	
	(1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier		
	(3) Transferred to separate account		
	(4) Other (specify below)		
		16722	
	(5) Total deductions	7e(5)	466 4.634.44.45.63.4
	f Balance at the end of the current year (subtract e(5) from d).	7f	

Page	Ĺ

Par	weitare Benefit Contract Informa  If more than one contract covers the same gro				4			
	information may be combined for reporting pur	pos pos	es if such contracts are exp	employer(s) or membe perience-rated as a ur	ers or แ nit. Wh	ne same empli ere contracts d	oyee :ove	i organization(s), the r individual emplovees.
	the entire group of such individual contracts wi							, , , , , , , , , , , , , , , , , , , ,
8	Benefit and contract type (check all applicable boxes)							
	a Health (other than dental or vision)	b	Dental	C Vision			d┌	Life insurance
	e Temporary disability (accident and sickness)	f	Long-term disability	g Supplementa	l unem	plovment	hΓ	Prescription drug
	i Stop loss (large deductible)	i	HMO contract	k PPO contract			ïF	Indemnity contract
	m Other (specify) ▶	•					٠ ـ	J mooning contract
	TIL Other (Specify)							
9	Experience-rated contracts							
а	Premiums: (1) Amount received	٠		9a(1)				
	(2) Increase (decrease) in amount due but unpaid	•		9a(2)				
	(3) Increase (decrease) in unearned premium reserve	/0		9a(3)				<b>建筑</b>
_	(4) Eamed ((1) + (2) - (3))					9a(4)		
þ	Benefit charges: (1) Claims paid	•		9b(1)			1	
	(—)	-		9b(2)				
	(3) Incurred claims (add (1) and (2))				• •	9b(3)	┡	
	(4) Claims charged					9b(4)	¥2007	
С	Remainder of premium: (1) Retention charges (on a			0-41/81				
	(A) Commissions			9c(1)(A)				
	(B) Administrative service or other fees			9c(1)(B)			-	
	(C) Other specific acquisition costs			9c(1)(C)			-12	
	(D) Other expenses			9c(1)(D)		-	<b>-</b> III	
	(E) Taxes			9c(1)(E) 9c(1)(F)			-	
	(F) Charges for risks or other contingencies			9c(1)(G)			+	
	(G) Other retention charges	•		30(1)(0)		9c(1)(H)	(£222	<u> </u>
	(2) Dividends or retroactive rate refunds. (The amo	· ·	were paid in cash,	or Credited.)	• •	9c(2)	+	
d	Status of policyholder reserves at end of year: (1) A		<b>—</b> '		•	9d(1)	t	
u	(2) Claim reserves	1100	in held to provide benefits t	and remement	• •	9d(2)	+	<u>-</u>
	(3) Other reserves	· ·				9c(3)	╁	
e	Dividends or retroactive rate refunds due. (Do not inc	clud	e amount entered in c(2).)			9e	t	
10	Nonexperience-rated contracts:		<u> </u>				C i	
а	Total premiums or subscription charges paid to carrie	ŀľ				10a		
b	If the carrier, service, or other organization incurred a	ny s	pecific costs in connection	with the acquisition o	r			
	retention of the contract or policy, other than reported	l in l	Part I, item 2 above, report	amount		10b		
Sp	ecify nature of costs >							
Par	Provision of Information							
	Did the insurance company fail to provide any informat	ion	necessary to complete Sch	edule A?	Пу	es	П	No

#### SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

► File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

A Name of plan	A Name of plan  ICHAEL A. LETTRICK, MD, PC SafeHarbor 401(k) Profit Sharing P1			B Three-di plan nun		<b>&gt;</b>	001
MICHAEL A. LETTRI	CK, MD, PC	SafeHarbor 401(k) Pro	ofit Sharing Pl	1 2	A DANS THE STATE OF THE STATE O	p p in the	
C Plan sponsor's nam	e as shown on I	ine 2a of Form 5500.		D Employe	er Indentification Num	nber (EIN	1)
MICHAEL A. LETTRI	CK, MD, PC				14-1823167		
Part Information on a separate	ion Conceri le Schedule A. I	ning Insurance Contra ndividual contracts grouped as	ct Coverage, Fee a unit in Parts II and III	es, and Co	mmissions Project on a single Sche	ovide info	ormation for each contra
1 Coverage Information					<b>.</b>		
(a) Name of insurance of	arrier						
NATIONWIDE LIFE I	NSURANCE CO	) <b>.</b>					
/EX E(E)	(c) NAIC	(d) Contract or	(e) Approximate		P	olicy or c	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year			(g) To
31-4156830	66869	0000MICH01NY001		8 1			12/31/2010
2 Insurance fee and o descending order of	commission info f the amount pai	mation. Enter the total fees and	d total commissions pai	d. List in item	3 the agents, broke	rs, and o	ther persons in
<b>(a)</b> To	tal amount of co	mmissions paid		(b) Tota	al amount of fees pa	id	
		0				0	· · · · · · · · · · · · · · · · · · ·
3 Persons receiving o		fees. (Complete as many entr					
	(a) Name a	nd address of the agent, broker	r, or other person to who	om commissi	ons or fees were pai	d	
		··					
(b) Amount of sale			es and other commissi				
commissions	paid	(C) Amount		(d) Purpose	<u> </u>		(e) Organization code
	-						
		nd address of the agent, broker					
			•			<del>-</del>	
(b) Amount of sale	s and hase	Fe	es and other commission	ons paid		-	
commissions		(C) Amount		(d) Purpose			(e) Organization code
For Dononwork Badwat		1.0100.0				_	

Schedule A (Form 550)	0) 2010	Page <b>2-</b>	_
(a) Nan	ne and address of the agent, bro	oker or other person to whom commissions or fees were	e paid
			· .
(b) Amount of sales and base	1 :	Fees and other commissions paid	<del></del>
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(G) / William	(a) i dipose	(e) Organization code
(a) Nan		eker or other person to whom commissions or fees were	
	-		
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
TO SEE CO. LOW AND A PARK NOW SEE AND A SECOND SEE			
(a) Nan		oker or other person to whom commissions or fees were	71.4-1-2-4-1
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization cod
		eker or other person to whom commissions or fees were	e paid
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nan	e and address of the agent, bro	oker or other person to whom commissions or fees were	e paid
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

P	aq	e	3

Pi	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treate this report.	d as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at year end	
5	Current value of plan's interest under this contract in separate accounts at year end	423,870
6	Contracts With Allocated Funds:  a State the basis of premium rates  AS PUBLISHED/FILED BY INSURANCE CO	
	b Premiums paid to carrier	21,780
	C Premiums due but unpaid at the end of the year	0
	d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	653
	Specify nature of costs ▶	<del> 1</del>
	CONTRACT COMMISSIONS	
	€ Type of contract (1) x individual policies (2) group deferred annuity	
	(3) ☐ other (specify) ►	
	f contract purchased in whole as in part to distribute benefits from a terminating plan shock have	
7	f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here  Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
2		
	(3) ☐ guaranteed investment (4) ☐ other ►	
t	Balance at the end of the previous year	
C	C Additions: (1) Contributions deposited during the year	
	(2) Dividends and credits	
	(3) Interest credited during the year	177
	(4) Transferred from separate account	
	(5) Other (specify below)	
		40.00
	(6) Total additions	
C	Total of balance and additions (add b and c(6)) · · · · · · · · · · · · · · · · · ·	
E	porticinate processing the processing the processing and the processing the processing the processing the processing the process of the processing the proce	Ye Yes
	(1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1)	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	1 (100 mm) 1 (100 mm) 1 (100 mm)
	(4) Other (specify below)	
		1000
		12
	(5) Total deductions	
f	Balance at the end of the current year (subtract e(5) from d)	

Pa	'n	6	4

Par	Welfare Benefit Contract Information		
	If more than one contract covers the same group of employees of the same information may be combined for reporting purposes if such contracts are exthe entire group of such individual contracts with each carrier may be treated	perience-rated as a unit. Where contracts of	
8	EDWISTAL		
U	Benefit and contract type (check all applicable boxes)  a  Health (other than dental or vision)	c Vision	d ☐ Life insurance
	- H	H ' '	." H
	H and the manner of the manner	g Supplemental unemployment	h Prescription drug
	i ☐ Stop loss (large deductible) j ☐ HMO contract	k ∐ PPO contract	I Indemnity contract
	m∐ Other (specify) ▶		
9	Experience-rated contracts		5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
а	Premiums: (1) Amount received	9a(1)	or the state of th
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))	9a(4)	
b	Benefit charges: (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))	9b(3)	
	(4) Claims charged	9b(4)	
C	Remainder of premium: (1) Retention charges (on an accrual basis)		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	The state of the s
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	1
	(G) Other retention charges	9c(1)(G)	T www.f
	(H) Total retention	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (The amounts were  paid in cash		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits		
	(2) Claim reserves	9d(2)	
	(3) Other reserves	9c(3)	
е	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	9e	
10	Nonexperience-rated contracts:		
а	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection	n with the acquisition or	
	retention of the contract or policy, other than reported in Part I, item 2 above, report	t amount 10b	
Sp	ecify nature of costs ▶		
Pa	TIV Provision of Information		
11	hid the insurance company fail to provide any information necessary to complete Sc	hadula A2 Vec	□ No

#### SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

#### Financial Information -- Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

OMB No. 1210-0110

2010

	Internal Revenue Service	I IIIemai n	evenue Code (trie C	ode).				
	Department of Labor nployee Benefits Security Administration	► File as an a	ttachment to For	n 5500.		-	This Fo	orm is Open to Public Inspection.
	Pension Benefit Guaranty Corporation	<u> </u>						пореспол.
	calendar plan year 2010 or fiscal plan	year beginning 01/01/20	010	and ending		/2010		
	Name of plan				<b>B</b> Three	•		
	MICHAEL A. LETTRICK, MD,	PC SafeHarbor 401(k) Pr	ofit Sharing	Plan	plan n	umber		001
C	Plan sponsor's name as shown on lin	e 2a of Form 5500			D Emplo	ver Ident	tification N	lumber (EIN)
	MICHAEL A. LETTRICK, MD,				-	, 823167		,,
	lete Schedule I if the plan covered few		heginning of the plan	vear Yourn	av also cor	nniete So	chedule Li	vou are filing as a
small	plan under the 80-120 participant rule	(see instructions). Complete Scher	dule H if reporting as	a large plan	or DFE.			, you are ming as a
<b>₩</b> ₽			ii					
assets benefi	t below the current value of assets an held in more than one trust. Do not e t at a future date. Include all income noe carriers. Round off amounts to t	enter the value of the portion of an i and expenses of the plan including	nsurance contract th	at guarantee	s during thi	s plan ye	ar to pay	a specific dollar
1	Plan Assets and Liabilities:			(a) Beginnii	ng of Year		( <b>b</b> ) End	d of Year
а	Total plan assets	. <b></b> .	1a		394	, 681		501,629
b	Total plan liabilities	. <b></b> .	1b			0		
C	Net plan assets (subtract line 1b from	n line 1a)	1c		394	1,681		501,629
2	Income, Expenses, and Transfe	ers for this Plan Year:		(a) Amo	unt		(b)	Total
а	Contributions received or receivable				7 J.			
	(1) Employers		2a(1)		1:	1,122	la .	
	(2) Participants				34	1,880		
	(3) Others (including rollovers)							
b	Noncash contributions							
C	Other income	. <b></b> .	2c		64	1,936		
ď	Total income (add lines 2a(1), 2a(2),							110,93
e	Benefits paid (including direct rollove		2e			3,750		
ť	Corrective distributions (see instructi					0		
g	Certain deemed distributions of parti	•	<del> </del>					į.
9	(see instructions)		2g			اه		
h	Administrative service providers (sal					0		
i			A.			240		000 402 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
i	Total expenses (add lines 2e, 2f, 2g,		<b></b>		T07///27/2/			3,990
k	Net income (loss) (subtract line 2j fro					<b>.</b>		106,94
ï	Transfers to (from) the plan (see ins					)		
3	Specific Assets: If the plan held asseremaining in the plan as of the end of the by-line basis unless the trust meets one	ts at anytime during the plan year in an	y of the following categ an's interest in a comm	ories, check "\	es" and ent	er the curr	rent value o	f any assets ne plan on a line-
					Yes	No	Ar	nount
а	Partnership/joint venture interests			3ε	_	x		
b	Employer real property			3t		x		
c	Real estate (other than employer rea			<u>30</u>	<del></del>	x		
ď	Employer securities			30		x		

			Yes	No	Amour	nt	
3f	Loans (other than to participants)	3f		х			
g	Tangible personal property	3g		х			
art j	Compliance Questions						
4	During the plan year:		Yes	No	Amou	nt	
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiductary Correction Program)	4a	790 - Ye	x			
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		x			
c	Were any leases to which the plan was a party in default or classified during the year as	i i					加緬紅
	$uncollectible? \dots \dots$	4c		X		ten i dian	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		x			
е	Was the plan covered by a fidelity bond?	4e	x				5,0
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f	0.22	x			
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		x			<u> </u>
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h	0.000	x			\$17.75°
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		x			
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		x			
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No", attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	x				
ı	Has the plan falled to provide any benefit when due under the plan? $\dots \dots \dots \dots \dots \dots$	41	Min.	x	Mendelle et la experience de la compa	di nakitatin eta	ingge to the c
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		x			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n	<u> </u>				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?	1 411	<u> </u>		(200)		NOTE OF THE
٧	If "Yes," enter the amount of any plan assets that reverted to the employer this year	es 🗵	No	Amount	:		
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident transferred. (See instructions.)	ify the	plan(s) to	which a	ssets or liabilitie	s were	
	5b(1) Name of plan(s)	5	o(2)	EIN(s)	5t	(3) P	N(s)
		1			1		

#### SCHEDULE R (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

#### **Retirement Plan Information**

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public

	Pension Benefit Guaranty Corporation					Inspect	ion.
Fo	r calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending	12	/31/2	010			
Α	Name of plan	В	Three-	digit			
	·		pian nu	mber	ì		
MT	CHAEL A. LETTRICK, MD, PC SafeHarbor 401(k) Profit Sharing Plan		(PN)	•		(	001
			×10			7.4	
С	Plan sponsor's name as shown on line 2a of Form 5500	D	Employ	er Ident	ificatio	n Number (	EIN)
	CHAEL A. LETTRICK, MD, PC	i		23167			,
	Distributions					• •	
4-7	references to distributions relate only to payments of benefits during the plan year.						
1	Total value of distributions paid in property other than in cash or the forms of property specified in the		Г	<del></del> T			
•	instructions		. L	1			
2	Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during payors who paid the greatest dollar amounts of benefits):	the y	ear (if n	nore tha	n two,	enter EINs	of the two
	EIN(s): 31-4156830						
	Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.						
3	Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plants	an	Г	<del>- </del>			
	year		<u> </u>	3			
P	Funding Information (If the plan is not subject to the minimum funding requirements of security ERISA section 302, skip this Part)	ectio	n 412 o	f the Inte	emal F	Revenue Co	de or
4	Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?		•	□ Y	'es	☐ No	☐ N/A
	if the plan is a defined benefit plan, go to line 8.						
5	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 ruling letter granting the waiver.  Date:		Month		•	y Ye	ear
	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remai	nder	of this	schedu	le.		
6	<b>a</b> Enter the minimum required contribution for this plan year		·	6a			
	<b>b</b> Enter the amount contributed by the employer to the plan for this plan year		· L	6b			
	C Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		. [	6c			
	If you completed line 6c, skip lines 8 and 9.						
7	Will the minimum funding amount reported on line 6c be met by the funding deadline?		•	<u></u>	'es	☐ No	□ N/A
8	If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providi automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agreewith the change?	.66	•	\	es	☐ No	□ N/A
ØP.	Amendments						
9	If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate boxe(es). If no, check the "No" box	rease	. $\Box$	Decrea	ıse	☐ Both	∏ No
	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of skip this Part.	אווו וכ	meme	u neven	iue CU		
10	Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay a	ny e	xempt l	oan? .		Yes	
1	1 a Does the ESOP hold any preferred stock?				• •	Yes Yes	☐ No
	If the ESOPhas an outstanding exempt loan with the employer as lender, is such loan part of a "back (See instructions for definition of "back-to-back" loan.)				<u></u>	☐ Yes	□ No
12	2 Does the ESOP hold any stock that is not readily tradable on an established securities market?					☐ Yes	☐ No

		Schedule R (Form 5500) 2010 Page 2-
	έγ»	Additional Information for Multiample on Defined Density Density Density
Pari		
		er the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in ars). See instructions. Complete as many entries as needed to report all applicable employers.
a	_	Name of contributing employer
b	)	EIN C Dollar amount contributed by employer
d	ı	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	•	Contribution rate information(if more than one rate applies, check this box complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)
	-	(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
a	_	Name of contributing employer
b	-	EIN C Dollar amount contributed by employer
	<u>.</u>	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	)	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)
		(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
а	1	Name of contributing employer
b	)	EIN C Dollar amount contributed by employer
d	1	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	•	Contribution rate information(if more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)
		(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
a	ì	Name of contributing employer
b	)	EIN C Dollar amount contributed by employer
d	1	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	•	Contribution rate information (if more than one rate applies, check this box complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)
		(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
<u>a</u>	_	Name of contributing employer
	_	EIN C Dollar amount contributed by employer
d	<u> </u>	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	•	Contribution rate information(if more than one rate applies, check this box complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)
		(2) Base unit measure: Hourly Weekly Unit of production Other (specify):
а	ì_	Name of contributing employer
b	<u> </u>	EIN C Dollar amount contributed by employer
d	i 	Date collective bargaining agreement expires (if employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.)  Month Day Year
е	)	Contribution rate information(if more than one rate applies, check this box complete items 13e(1) and 13e(2).)  (1) Contribution rate (in dollars and cents)

(2) Base unit measure: Hourly Weekly Unit of production Other (specify):

	Schedule R (Form 5500) 2010 Page 3		
14	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the partipant for:		
	a The current year	14a	
	b The plan year immediately preceding the current plan year	14b	
	C The second preceding plan year	14c	
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make a employer contribution during the current plan year to:	าก	
	The corresponding number for the plan year immediately preceding the current plan year	15a	
	b The corresponding number for the second preceding plan year	15b	
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:		
	a Enter the number of employers who withdrew during the preceding plan year	16a	
	b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, chec supplemental information to be included as an attachment.	k box and	d see instructions regarding
Pe	Additional Information for Single-Employer and Multiemployer Defined Ben	efit Pe	nsion Plans
18	If any liabilities to participants or their beneficiaries under the plan as of end of the plan year consist (in whole or in pa and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instri information to be included as an attachment	rt) of liab uctions re	ilities to such participants garding supplemental
19	If the total number of participants is 1,000 or more, complete items (a) through (c)		
	Enter the percentage of plan assets held as: Stock:% Investment-Grade Debt: % High-Yield Debt: % Real Estate:		_ % Other:%
	b Provide the average duration of the combined investment-grade and high-yeild debt:  ☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-	21 years	21 years or more
	What duration measure was used to calculate item 19(b)?  Effective duration Macaulay duration Modified duration Other (specify):		

#### Form 5558 (Rev. January 2008) Department of the Treasury Internal Revenue Service

# Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

File With IRS Only

Part	Identification						
A	Name of filer, plan administrator, or plan sponsor (see instructions)	В			fying number		ions).
••	MICHAEL A. LETTRICK, MD, PC		Empl	oyer ide	ntification num	ber (EIN).	
	Number, street, and room or suite no. (If a P.O. box, see instructions.)		14-	1823	167		
	1528 COLUMBIA TURNPIKE		Socia	l securi	y number (SS	N)	
	City or town, state and ZIP code						
	CASTLETON NY 12033	_				_	
С	Plan name		Pla: numi	-		n year endi DD	ng YYYY
		+	·	, ,	MM	1 00	1111
	MICHAEL A. LETTRICK, MD, PC SafeHarbor 401(k) Profit	ا ،	1 0	1 1	12	31	2010
'	MICHAEL A. BETTRICK, ND, PC Salenarbol 401(K, Fibile	3 0	1	1	12	31	2010
9	2		1	1			
-			1	i			1
3			<u>.</u>	i .			
Part	Extension of Time to File Form 5500 or Form 5500-EZ (s	ee inst	ructio	ons)			
1	I request an extension of time until _10 / 17 / 2011 to file Fo	m 5500	or Fo	orm 550	00-EZ.		
	The application <b>Is automatically approved</b> to the date shown on line 1 (above normal due date of Form 5500 or 5500-EZ for which this extension is requeste months after the normal due date.						
	You must attach a copy of this Form 5558 to each Form 5500 and 5500-Ea	filed a	fter ti	e due	date for the	plans listed	in C above.
Note.	A signature is not required if you are requesting an extension to file Form 5500	or Form	5500	)-EZ			
Pari	Extension of Time to File Form 5330 (see instructions)						
2	I request an extension of time until to file Form 5330, after the second			due da	ate of Form 5	330.	
а	Enter the Code section(s) imposing the tax	. ▶	<u>a</u>				
b	Enter the payment amount attached				•	ь	
_	For excise taxes under section 4980 or 4980F of the Code, enter the revision/a	mende	ant d	ate			
3	State in detail why you need the extension	menun	ieni u				
							•

Under penalties of perjury, I declare that to the best of my knowledge and belief the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Form 5558 (Rev. January 2008) Department of the Treasury Internal Revenue Service

Signature >

# Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

File With IRS Only

art I	Identification						
•	ne of filer, plan administrator, or plan sponsor (see instructions)	愚	Filer's Emplo	identif oyer iden	ying number tification num	(see instructi ber (EIN).	ons).
	nber, street, and room or suite no. (If a P.O. box, see instructions.)	1	14-	18231	67		
	28 COLUMBIA TURNPIKE	╝	Socia	security	number (SSI	N)	
_	or town, state and ZIP code						
-	ASTLETON NY 12033						
3	Plan name		Plan	1	Pla	n year endi	
			numb	er	MM	DD	YYYY
			1	1			•
1 <u>M</u> I	CHAEL A. LETTRICK, MD, PC SafeHarbor 401(k)	0	10	11	12	31	2010
			1	1			
2							<u> </u>
			i	1			
3							
art II	Extension of Time to File Form 5500 or Form 5500-EZ (s				0.57		· · ·
nor	e application is automatically approved to the date shown on line 1 (above mat due date of Form 5500 or 5500-EZ for which this extension is requeste on this after the normal due date.	e) if: (a) d, and (	the Fo	rm 555 date on	8 is filed on line 1 is no	or before the more the 2 1	1 <i>1</i> /2
ma							
					1_4_ #0 145		In O abarr
	u must attach a copy of this Form 5558 to each Form 5500 and 5500-E	Z filed a	ifter th	e due c	iate for the	plans listed	in C above
Yo	u must attach a copy of this Form 5558 to each Form 5500 and 5500-E				date for the	plans listed	in C above
Yo					date for the	plans listed	in C above
Youte, A si	u must attach a copy of this Form 5558 to each Form 5500 and 5500-Ei	or Form	<u>5500</u>	-EZ			in C above
Your te. A si	u must attach a copy of this Form 5558 to each Form 5500 and 5500-Each ignature is not required if you are requesting an extension to file Form 5500 Extension of Time to File Form 5330 (see instructions)	or Form	<u>5500</u>	-EZ			in C above
You te. A si art III 2 I re You a Ent	u must attach a copy of this Form 5558 to each Form 5500 and 5500-Each ignature is not required if you are requesting an extension to file Form 5500 Extension of Time to File Form 5330 (see instructions)  equest an extension of time until	or Form	0. a	due da	te of Form 5		in C above
You te. A si art III 2 I re You a En to En to En to For	u must attach a copy of this Form 5558 to each Form 5500 and 5500-Ezignature is not required if you are requesting an extension to file Form 5500  Extension of Time to File Form 5330 (see instructions)  equest an extension of time until	or Form	0. a	due da	te of Form 5		in C above
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