Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

HERE

SIGN

HERE

SIGN **HERE**

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 Identif	ication Information	<u> </u>		
For calenda	ar plan year 2010 or fiscal pla		and ending 12/31/20	10	
A This ret	urn/report is for:	a multiemployer plan; a single-employer plan;	a multiple-employer plan; or a DFE (specify)		
B This ret	urn/report is:	the first return/report; an amended return/report;	the final return/report; a short plan year return/report (less tha	n 12 months).	
C If the pla	an is a collectively-bargained p	olan, check here			
D Check b	oox if filing under:	X Form 5558;	automatic extension;	the DFVC program;	
		special extension (enter descripti	on)		
Part II	Basic Plan Informa	tion—enter all requested information			
1a Name	of plan	ASSOCIATES, PC 401(K)/PROFIT SH	IARING PLAN	1b Three-digit plan number (PN) ▶	001
		, , , , , , , , , , , , , , , , , , , ,		1c Effective date of pla 01/01/1998	n
	consor's name and address (ess should include room or suit	employer, if for a single-employer plan) e no.)		2b Employer Identificat Number (EIN)	ion
NORTHEA	ST EMERGENCY MEDICAL	ASSOCIATES, PC		14-1797263	
40.844.2/14/5	THE PRINCE OF THE COL			2c Sponsor's telephone number 518-383-4008)
	ELL DRIVE SUITE 205 PARK, NY 12065	10 MAXWELL SUITE 205 CLIFTON PAR		2d Business code (see instructions) 621111	
Caution: A	penalty for the late or inco	mplete filing of this return/report wil	I be assessed unless reasonable cause is	established.	
			lare that I have examined this return/report, incort, and to the best of my knowledge and belie		

10/01/2011

10/01/2011

Date

Date

Date

STANLEY W DOCYK MD

STANLEY W DOCYK MD

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

Signature of DFE Enter name of individual signing as DFE For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Filed with authorized/valid electronic signature.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of plan administrator

Form 5500 (2010) v.092307.1

Form 5500 (2010) Page **2**

AXWELL DRIVE SUITE 205 TON PARK, NY 12065 If the name and/or EIN of the plan sponsor has changed since the last return he plan number from the last return/report: Sponsor's name Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans completed to reparticipants	ete only lines 6a, 6t	o, 6c, and 6d).	and 5	dministrator's telephone umber 8-383-4008 4b EIN 4c PN 9
Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans completed to participants). Active participants	ete only lines 6a, 6t	o, 6c, and 6d).	5 . 6a	4c PN
Cotal number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans completed to participants). Retired or separated participants receiving benefits. Other retired or separated participants entitled to future benefits. Subtotal. Add lines 6a, 6b, and 6c.			. 6a	
Number of participants as of the end of the plan year (welfare plans completed to participants			. 6a	9
Active participants Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits Subtotal. Add lines 6a, 6b, and 6c			. 6a	
Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits Subtotal. Add lines 6a, 6b, and 6c				
Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits Subtotal. Add lines 6a, 6b, and 6c				
Other retired or separated participants entitled to future benefits				
Subtotal. Add lines 6a , 6b , and 6c			. 6b	6
			. 6c	0
Description of the subsection			6d	6
Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits		. 6e	
otal. Add lines 6d and 6e			. 6f	6
Number of participants with account balances as of the end of the plan yea complete this item)	` •	•	. 6g	3
Number of participants that terminated employment during the plan year wi			6h	
Enter the total number of employers obligated to contribute to the plan (onl	y multiemployer pla	ans complete this item)	7	
1) Insurance 2) Code section 412(e)(3) insurance contracts 3) Trust	9b Plan benef (1) (2) (3) (4)	Insurance Code section 412(e)(3) Trust	insurand	,
Pension Schedules 1) R (Retirement Plan Information)	_	H (Financial Inform I (Financial Inform A (Insurance Inform C (Service Provide D (DFE/Participati	nation) nation – mation) er Inform ng Plan	Small Plan) nation) Information)
t (((((((((((((((((((Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are Pension Schedules	Plan funding arrangement (check all that apply) (1)	the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in Plan funding arrangement (check all that apply) Plan funding arrangement (check all that apply) Insurance	the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instance Plan funding arrangement (check all that apply) 10

SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation 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 Inspection

· · · · · · · · · · · · · · · · · · ·				mopeotion
For calendar plan year 2010 or fiscal plan year beginning 01/01/2010		and ending 12	/31/201	0
A Name of plan NORTHEAST EMERGENCY MEDICAL ASSOCIATES, PC 401(K)/PROFIT SHARING PLAN	В	Three-digit plan number (PN)	•	001
C Plan sponsor's name as shown on line 2a of Form 5500 NORTHEAST EMERGENCY MEDICAL ASSOCIATES, PC	D	Employer Identificati 14-1797263	ion Nun	nber (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.

Part I 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	1040953	355741
b	Total plan liabilities	. 1b	0	
С	Net plan assets (subtract line 1b from line 1a)	1c	1040953	355741
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
а	Contributions received or receivable:			
	(1) Employers	. 2a(1)		
	(2) Participants	2a(2)		
	(3) Others (including rollovers)	. 2a(3)		
b	Noncash contributions	. 2b		
С	Other income	. 2c	44502	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	. 2d		44502
е	Benefits paid (including direct rollovers)	. 2e	727855	
f	Corrective distributions (see instructions)	. 2f		
g	Certain deemed distributions of participant loans (see instructions)	. 2g		
h	Administrative service providers (salaries, fees, and commissions)	. 2h		
i	Other expenses	. 2i	1859	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		729714
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		-685212
	Transfers to (from) the plan (see instructions)	. 2I		

3 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 line-by-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	
С	Real estate (other than employer real property)	3с		X	
d	Employer securities	3d		X	
	Participant loans			X	

	Schedule I (Form 5500) 2010 Page 2-			_	
	_		Yes	No	Amount
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	
Pä	art II Compliance Questions				
	During the plan year:		Yes	No	Amount
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 Fiduciary Correction Program.)	4a		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 participant's account balance.	4b		X	
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		Х	
е	Was the plan covered by a fidelity bond?	4e	X		10000
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		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		Х	
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		X	
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		Х	
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		Х	
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 an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
ı	Has the plan failed to provide any benefit when due under the plan?	41		X	
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			
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year	_	es XI	No Am	ount:

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(1) Name of plan(s)	5b(2) EIN(s)	5b(3) 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	calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and 6	ending	g 1	12/31/2	010			
	Name of plan THEAST EMERGENCY MEDICAL ASSOCIATES, PC 401(K)/PROFIT SHARING PLAN	В	Three plan (PN)	numbe	er •		001	
		_						
	Plan sponsor's name as shown on line 2a of Form 5500 RTHEAST EMERGENCY MEDICAL ASSOCIATES, PC	D	Empl	oyer Id	entifica	ition Nur	nber (E	N)
NOIN	THEAST EMERGENCY MEDICAL ASSOCIATES, TO		14-	179726	63			
D-	ant 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		L	1				
2	Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries dur payors who paid the greatest dollar amounts of benefits):	ing th	e year	(if mor	e than	two, ent	er EINs	of the two
	EIN(s):14-1807897							
	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				
Pa	Funding Information (If the plan is not subject to the minimum funding requirements of ERISA section 302, skip this Part)	of sec	tion of		the Int	ernal Re	evenue (Code or
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.							Ш
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	th		Da			Year	
	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the rei				,		rour_	
6	a Enter the minimum required contribution for this plan year			6a				
	b Enter the amount contributed by the employer to the plan for this plan year			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				
			L	UC	1			
	If you completed line 6c, ckin lines 9 and 0							
7	If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline?							
7	If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline?				Yes		No	□ N/A
7	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree						
	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree			Yes		No No	□ N/A
8	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree						
8	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree						
8 Pa	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree		Decre	Yes			
8 Pa	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree	; 	_	Yes		No oth	□ N/A
8 Pa	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree	of the	Interna	Yes ease	nue Cod	No oth	N/A
Pa	Will the minimum funding amount reported on line 6c be met by the funding deadline?	viding agree ease (e)(7)	of the	Interna	Yes ease I Reve	nue Cod	No oth	N/A No
8 Pa	Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure provautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator with the change? Amendments 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 box(es). If no, check the "No" box. Incre Incre INCRE Were unallocated employer securities or proceeds from the sale of unallocated securities used to repair.	ease (e)(7) ay any	of the	Interna pt loan k" loan	Yes Pase I Reve ?	nue Coo	No oth le,	N/A No No No

Page 2 ·

Schedule R (Form 5500) 2010

Par	t V	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									
		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	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	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):									
	a	Name of contributing amplayor									
	a b	Name of contributing employer EIN C Dollar amount contributed by employer									
	<u>บ</u> d										
		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 .

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 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 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, 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 eyears 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:

Northeast Emergency Medical Associates, PC 401(K)/Profit Sharing Plan

EIN/PN:

14-1797263/001

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

(sigh)

10.1.11

(date)

Plan Sporsor

(sign)

10.1.11

(date)

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

					mspection					
Part I	Annual Report	Identification Information								
For the ca	alendar plan year 201	0 or fiscal plan year beginning 01	/01/2010	and ending 12/31	./2010					
A This re	turn/report is for:	a multiemployer plan;		a multiple-employer (r plan; or					
		🔀 a single-employer plan;		a DFE (specify)						
B This re	turn/report is:	the final return/report	port; return/report (less than 12 months).							
C If the p	lan is a collectively-bar	gained plan, check here				. ▶□				
•	box if filing under:	Form 5558:		automatic extension;	the DFVC pr	ogram:				
D CHECK	box ir ming under.	special extension (enter description	on)			-g				
Don't II	Besie Blan Info	rmation enter all requested in	_ `							
Part II		rmation enter an requested in	HOITIAUOII.		1b Three-digit plan					
	ne of plan	y Medical Associates, PC 4	IN1(K)/Profit S	haring Plan	number (PN) ▶	001				
NOI	theast Emergenc	y madical Associates, 10 4	.01(11),110110		1c Effective date of pla 01/01/1998	n				
2a Plan	sponsor's name and a	ddress (employer, if for a single-emplo	yer plan)		2b Employer Identificat	ion				
	fress should include ro				Number (EIN)					
, No.	theset Emergenc	y Medical Associates, PC			14-1797263					
NOI	Cheast Emergenc	y Madrear Associates, 10			2c Sponsor's telephone					
					number					
					(518) 383-400	В				
10	Maxwell Drive S	uite 205			2d Business code (see					
					instructions)					
US	CLIFTON PARK	NY 12065			621111					
0	h manadhu fan Abrilada a	or incomplete filing of this return/rep	art will be accessed	uniose rozeonable cause is	actablished					
		ner penalties set forth in the instructions				chedules.				
statement	s and attachn ents, as v	well as the electronic version of this ret	urn/report, and to the	best of my knowledge and be	elief, it is true, correct, and	complete.				
2:21:	1/1	15								
SIGN	March	, Woods	16.1.11	STANLEY W. DOCYK,	MD					
	Signature/pf plan a	iministrator //	Date	Enter name of individual si	gning as plan administrato	or				
SIGN HERE	Stank	Do Dorde	10.1.11	STANLEY W. DOCYK,	MD					
	Signature of employ	er/plan sponsor// V	Date	Enter name of individual si	gning as employer or plan	sponsor				
SIGN HERE		<i>V</i>								
	Signature of DFE		Date	Enter name of individual si	gning as DFE	_				

_	Form 5500 (2010)			!	<u>Page</u>	2			_				
3a	Plan administrator's name and address (if same as plan sponsor, enter "Same")						3Ь,	3b Administrator's EIN					
									3c 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:	rn/repor	filed	foi	r this	plan, e	nter th	ne nam	e, EIN	and	4b EIN		
а	Sponsor's name										4c PN		
5	Total number of participants at the beginning of the plan year			_						5	9		
6	Number of participants as of the end of the plan year (welfare plans complet							<u> </u>	<u> </u>				
а	Active participants		•							6a			
b	Retired or separated participants receiving benefits									6b	6		
C	Other retired or separated participants entitled to future benefits		•	•						6с	0		
d	Subtotal. Add lines 6a, 6b and 6c									6d	6		
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive b	enefi	ts						6e			
f	Total. Add lines 6d and 6e		•							6f	6		
g	Number of participants with account balances as of the end of the plan year complete this item)	•					olans 			6g	3		
h	Number of participants that terminated employment during the plan year with 100% vested									6h			
7	Enter the total number of employers obligated to contribute to the plan (only	multien	nploy	er	comp	lete th	is item	1) .		7			
	If the plan provides pension benefits, enter the applicable pension feature of 2E 2G 2J 3D If the plan provides welfare benefits, enter the applicable welfare feature co												
9a	Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) X Trust (4) General assets of the sponsor	!	(1) (2) (3) (4)	×	Insur Code Trust Gene	ance section	on 412 sets of	f the sp	nsurar onsor	ace co	ntracts		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	attache	d, an	id, 1	where	indica	ated, e	enter th	e num	ber at	tached. (See instructions)		
а	Pension Schedules (1) X R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial	(((((1) (2) (3) (4) (5)	X	I Scho	 -	(Fina (Fina (Insu (Sen (DFE	rance vice Pro E/Partic	nformat Informat ovider ipating	tion - S ation) Inform Plan	Information)		
	Information) - signed by the plan actuary	(6)				Fina	incial T	ransad	ction la	nformation)		

Sponsor Location Information

Sponsor name:

Northeast Emergency Medical Associates, PC

Sponsor DBA name: Sponsor care of name:

10 Maxwell Drive

Suite 205

US Clifton Park

NY 12065

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	Internal Revent	ne code (me c	Jude).		l	1	
	Department of Labor reployee Benefits Security Administration	▶ File as an attach	ment to For	m 5500.			Thi	is Form is Open to Public Inspection.
	Pension Benefit Guaranty Corporation							inspection.
	calendar plan year 2010 or fiscal plan	year beginning 01/01/2010		and endir		1/2010		
	Name of plan				B Thre	_		
	Northeast Emergency Medic	al Associates, PC 401(K)/Pr	rofit Shar	ing Pla	plan	number	•	001
С	Plan sponsor's name as shown on line	e 2a of Form 5500			D Emp	lover ider	ntificatio	on Number (EIN)
	Northeast Emergency Medic				1	179726:		
		ver than 100 participants as of the beginn	ning of the plan	n vear Vou r				e Lif you are filing as a
		(see instructions). Complete Schedule F				mpicte o	Circum	e in you are ming as a
	rt I Small Plan Financial			······································				
assets benefi	s held in more than one trust. Do not e	d liabilities, income, expenses, transfers inter the value of the portion of an insura and expenses of the plan including any to the nearest dollar.	nce contract tl	nat guarante	es during tl	nis plan ye	ear to p	ay a specific dollar
1	Plan Assets and Liabilities:			(a) Beginn	ning of Year	·	(b)	End of Year
а	Total plan assets		. <u> 1a</u>		1,04	0,953	ļ	355,741
b	Total plan liabilities			ļ		0		
<u>C</u>	Net plan assets (subtract line 1b from	n line 1a)	. 1c		1,04	0,953		355,741
2	Income, Expenses, and Transfe	ers for this Plan Year:	ł	(a) Am	ount		-	(b) Total
а				<u> </u>				
	(2) Participants							
	(3) Others (including rollovers) .		. 2a(3)					
b	Noncash contributions		. <u>2b</u>					
C	Other income		. <u>2c</u>		4	4,502		
d	Total income (add lines 2a(1), 2a(2),	2a(3), 2b, and 2c)		<u> </u>	·			44,502
е	Benefits paid (including direct rollove	ers)	. <u>2e</u>		72	7,855		
f	Corrective distributions (see instructi	ons)	. 2f					
g	Certain deemed distributions of parti	cipant loans						
	(see instructions)		. 2g				, •	
h	Administrative service providers (sal	aries, fees, and commissions)						
i	Other expenses					1,859		
j	Total expenses (add lines 2e, 2f, 2g,	2h and 2i)	. <u>2j</u>			`.		729,714
k	Net income (loss) (subtract line 2) fro	om line 2d)	. 2k		1 1			(685,212)
	Transfers to (from) the plan (see inst	tructions)	. 21					
3	Specific Assets: If the plan held asset remaining in the plan as of the end of the	ts at anytime during the plan year in any of the plan year. Allocate the value of the plan's int of the specific exceptions described in the ins	e following cate; erest in a comm	gories, check ' ningled trust co	"Yes" and er ontaining the	ter the cur assets of	rent valu	ue of any assets an one plan on a line-
					Yes	No		Amount
а	Partnership/joint venture interests			3	а	х		
b					b	x		
c		al property)			C	х		
_	Employer securities				d	х		

	Schedule I (Form 5500) 2010	Pag	ge 2- _	—	
			Yes	No	Amount
3f	Loans (other than to participants)	3f	165	x	Aniount
		3g	 	x	
g	Tangible personal property	<u> </u>	.l	J_^	<u>. I </u>
Part I	Compliance Questions				
4	During the plan year:		Yes	No	Amount
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 Fiduciary Correction Program)	4a		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	
_				 	1.3
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c	1	x	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions				
_	reported on line 4a.)	4d		х	
е	Was the plan covered by a fidelity bond?	4e	х	<u> </u>	10,000
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		х	
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?	4 g		x	
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		x	
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	х		
1	Has the plan failed to provide any benefit when due under the plan?	41		х	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		×	
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			
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?			•	
-	If "Yes," enter the amount of any plan assets that reverted to the employer this year	es 🗵	No	Amoun	ıt:
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident			o which a	assets or Habilities were
	transferred. (See instructions.) 5h(1) Name of plan(s)	5	b(2)	EIN(s)	5b(3) PN(s)
	5b(1) Name of plan(s)	٣	-\-/	(0)	
		<u> </u>			
	 -				
		 			
		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).

nue Code (the Code).

► File as an Attachment to Form 5500.

This Form is Open to Public

CMB No. 1210-0110

2010

	Pension Benefit Guaranty Corporation				Inspec	tion.
Fo	or calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and e	nding 1	2/31/20	10		
\overline{A}	Name of plan	В	Three-dig	jit		
		ĺ	plan num	ber	Ĭ	
No	ortheast Emergency Medical Associates, PC 401(K)/Profit Sharing Pls		(PN)	>	İ	001
C	Plan sponsor's name as shown on line 2a of Form 5500	D	Employe	Identifica	tion Number	(EIN)
	ortheast Emergency Medical Associates, PC		14-179	7263		
	art I Distributions	•				
	Il 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	• • •	[
2	Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries du payors who paid the greatest dollar amounts of benefits):	uring the	year (if mo	re than tw	o, enter EINs	of the two
	EIN(s): 14-1807897					
	Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.					
2		he nian		-		
3	year		:	3		
Ď.	art II Funding Information (If the plan is not subject to the minimum funding requirements			ne Interna	l Revenue Co	nde or
"	ERISA section 302, skip this Part)	01 3001	OII 4 12 OI (ic ancia		
4		2)?		Yes	☐ No	□ N/A
_	If the plan is a defined benefit plan, go to line 8.			_		
_						
5	plan year, see instructions and enter the date of the ruling letter granting the waiver. Date:		Month _		Day Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re		r of this so	hedule.	Day Y	ear
6	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re a Enter the minimum required contribution for this plan year		r of this se	hedule.	Day Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re a Enter the minimum required contribution for this plan year b Enter the amount contributed by the employer to the plan for this plan year		r of this so	hedule.	Day Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re a Enter the minimum required contribution for this plan year		r of this se	chedule.	Oay Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the re a Enter the minimum required contribution for this plan year b Enter the amount contributed by the employer to the plan for this plan year C Subtract the amount in line 6b from the amount in line 6a. Enter the result		or of this se	chedule.)ay Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year b Enter the amount contributed by the employer to the plan for this plan year 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)		or of this se	chedule.	Day Y	ear
	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline?	oviding	or of this se	chedule.		
6 7 8	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure propagation automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato	oviding	or of this se	chedule.	□ No	□ N/A
6 7 8	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure proautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change? Amendments	oviding	or of this se	chedule.	□ No	□ N/A
6 7 8	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year b Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure proautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change?	oviding or agree	or of this se	rhedule.	☐ No	□ N/A
6 7 8	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year b. Enter the amount contributed by the employer to the plan for this plan year 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) if you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure provautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change? If this is a defined benefit pension plan, were any amendments adopted during this plan	oviding	or of this se	chedule.	□ No	□ N/A
6 7 8	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure proautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change? 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	oviding agree	er of this se	Yes Yes	☐ No ☐ No ☐ Both	□ N/A
6 7 8 Pa 9	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure proautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change? 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 ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e) art IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)	oviding agree	e Internal F	Yes Yes Revenue (☐ No ☐ No ☐ Both	□ N/A □ N/A □ No
6 7 8 Pa 9	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real Enter the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure proautomatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change? 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 ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(escribed the part.	oviding agree	e Internal F	Yes Yes Revenue (☐ No ☐ No ☐ Both	N/A
6 7 8 Pa 9	plan year, see instructions and enter the date of the ruling letter granting the waiver. If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the real and a Enter the minimum required contribution for this plan year b Enter the amount contributed by the employer to the plan for this plan year 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) If you completed line 6c, skip lines 8 and 9. Will the minimum funding amount reported on line 6c be met by the funding deadline? If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure produced automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrato with the change?	oviding or agree	se De e Internal Fexempt loan	Yes Yes ecrease Revenue (☐ No ☐ No ☐ Both Code, . ☐ Yes	N/A N/A No No No

		Schedule R (Form 5500) 2010 Page Z-
District Control	(8) # (1)	
Pa		the state of the s
		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.
	а	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
ı	e	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
ı	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 b	Name of contributing employer C. Dellas amount contributed by completes
	_	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 in 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):
	2	
	a b	Name of contributing employer EIN C Dollar amount contributed by employer
		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
•	e	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):
	_	
	•	Name of contributing employer
		EIN C Dollar amount contributed by employer
		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):

	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 ar employer contribution during the current plan year to:	1	
	a 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, check supplemental information to be included as an attachment.	box and	see instructions regarding
Pa	art VI Additional Information for Single-Employer and Multiemployer Defined Bene	fit 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 part and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instruction information to be included as an attachment) of liabi	lities to such participants
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-yeild debt:		
	C 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

Par	I Identification											
A	Name of filer, plan administrator, or plan sponsor (see instructions) Northeast Emergency Medical Associates, PC	B	B Filer's identifying number (see instructions). Employer identification number (EIN).									
	Number, street, and room or suite no. (If a P.O. box, see instructions.)			14-	1797	263						
	10 Maxwell Drive Suite 205] §	Socia	l secun	ity number (S	SN)					
	City or town, state and ZIP code											
	CLIFTON PARK NY 12065											
C	Plan name			Plan	-		Plan year ending					
				ımb		MM	-	DD YYY				
	Northeast Emergency Medical Associates, PC 401(K)/Pro-	£C	ا <u>ا د</u> ا		 <u> 1</u> 	12		31	2010			
	3		 		 							
Par	Extension of Time to File Form 5500 or Form 5500-EZ (sec	-										
1	t request an extension of time until 10 / 17 / 2011 to file Form The application is automatically approved to the date shown on line 1 (above) normal due date of Form 5500 or 5500-EZ for which this extension is requested months after the normal due date.	if: (a) th	e Fo	rm 55:	58 is filed or						
Note.	You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ					date for the	ə plan:	s listed	In C above.			
	Extension of Time to File Form 5330 (see instructions)											
2	I request an extension of time until to file Form You may be approved for up to a six (6) month extension to file Form 5330, after			mal	due da	ate of Form	5330.					
а	Enter the Code section(s) imposing the tax	•	۱ -	a	<u> </u>							
b	Enter the payment amount attached	•	•			•	· <u>b</u>	-				
с 3	For excise taxes under section 4980 or 4980F of the Code, enter the revision/an State in detail why you need the extension	nend	mei	nt da	ite .	•	. <u>c</u>		·-			
•												
								_				
			_									
			_									
						-						