Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

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

2010

OMB Nos. 1210-0110 1210-0089

This Form is Open to Public Inspection

Pe	Pension Benefit Guaranty Corporation Complete all entrie	s in accord	dance with	n the instructions to the Form 5500	0-SF.	mspection	
Pa	art I Annual Report Identification Information						
For	calendar plan year 2010 or fiscal plan year beginning	01/01/2010)	and ending 1	2/31/2	2010	
Α 1	This return/report is for:	П	multiple-e	mployer plan (not multiemployer)		one-participant plan	
	This return/report is for:	X	final retur	n/report			
	an amended return/rep	H		year return/report (less than 12 mor	nths)		
•	™		•	, ,	11110)		
C	Check box if filing under:			extension		DFVC program	
	special extension (ente		,				
Pa	art II Basic Plan Information—enter all reques	sted informa	ation				
	Name of plan				1b	Three-digit	
A BR	ROOKLYN WOMAN'S MEDICAL PAVILION, P.C. 401(K) I	PLAN				plan number 001	
					10	(PN)	
					10	Effective date of plan 01/01/2007	
22	Plan sponsor's name and address (employer, if for single	a-employer	nlan)		2h	Employer Identification Number	
	COKLYN WOMANS MEDICAL PAVILION, P.C.	Chiployer	piari)		20	(EIN) 11-3446625	
					2c	Plan sponsor's telephone number	
	OURT STREET OKLYN, NY 11201					718-222-0123	
Ditto					2d	Business code (see instructions) 621111	
32	Plan administrator's name and address (if same as Plan	ononcor or	otor "Come	,"\	3h	Administrator's EIN	
A BR	ROOKLYN WOMANS MEDICAL PAVILION, P.C. 44	I COURT S	TREET		30	11-3446625	
	BI	ROOKLYN,	NY 11201		3c	Administrator's telephone number	
						718-222-0123	
	f the name and/or EIN of the plan sponsor has changed s			port filed for this plan, enter the	4b	EIN	
r	name, EIN, and the plan number from the last return/repo	rt. Sponsoi	rs name		4c	PN	
5a	Total number of participants at the beginning of the plan	vear			5a	27	
	Total number of participants at the end of the plan year	•		;		0	
				:	5b		
С	Total number of participants with account balances as o complete this item)			` .	5c	0	
6a	Were all of the plan's assets during the plan year invest					X Yes No	
_		_					
	under 29 CFR 2520.104-46? (See instructions on waive	• •		•		^ Yes No	
- D	If you answered "No" to either 6a or 6b, the plan car	not use Fo	orm 5500-	SF and must instead use Form 550	00.		
	rt III Financial Information						
7	Plan Assets and Liabilities			(a) Beginning of Year	,	(b) End of Year	
a	Total plan assets		7a	431347	_	0	
b	Total plan liabilities		7b	0		0	
C	Net plan assets (subtract line 7b from line 7a)		7c	431347		0	
8	Income, Expenses, and Transfers for this Plan Year			(a) Amount		(b) Total	
а	Contributions received or receivable from:		00(4)	5750)		
	(1) Employers		8a(1)	11558			
	(2) Participants		` '	9736	_		
	(3) Others (including rollovers)		8a(3)	15488	_		
b	Other income (loss)		8b	13400	•	42522	
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		8c			42532	
d	Benefits paid (including direct rollovers and insurance proprovide benefits)		8d	34430)		
е	Certain deemed and/or corrective distributions (see instr		8e	0	0		
f	Administrative service providers (salaries, fees, commiss	•	8f	56	5		
g	Other expenses	,	8g	C)		
h	Total expenses (add lines 8d, 8e, 8f, and 8g)		8h			34486	
i	Net income (loss) (subtract line 8h from line 8c)		8i			8046	
i	Transfers to (from) the plan (see instructions)			-439393	3		
,	(8j	400000			

	Form 5500-SF 2010 Page 2-						
Par	t IV Plan Characteristics						
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Chara	acteris	tic Co	des in	the instructi	ons:	
	2E 2F 2G 2J 2K 2T 3D						
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Charac	cterist	ic Coc	les in t	ne instruction	ons:	
art	V Compliance Questions						
0	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? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		Χ			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X			
С	Was the plan covered by a fidelity bond?	10c		X			
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		Χ			
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X			
f	Has the plan failed to provide any benefit when due under the plan?	10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10a		X			
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X			
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i					
art	VI Pension Funding Compliance						
1	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and comp 5500))					Yes	X No
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code	or se	ction 3	02 of E	ERISA?	Yes	X No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)						
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruction granting the waiver						
If	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.			Day _		. cai	
b	Enter the minimum required contribution for this plan year			12b			
	Enter the amount contributed by the employer to the plan for this plan year			12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of negative amount)		[12d			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No	N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted during the plan year or any prior year? If "Yes," enter the amount of any plan assets that reverted to the employer this year..... Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control X Yes No

of the PBGC?.....

If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)
A BRONX WOMEN'S MEDICAL PAVILION 401(K) PLAN	04-3785421	002
SAVANNAH WOMEN'S MEDICAL CENTER, INC. 401(K) PLAN	58-2170360	001

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	10/07/2011	SUZANNE KNORR
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

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

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

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

P	art I Annual Report Identification Information						
Foi)1/01/2	010 and ending		12/31/2010		
A	This return/report is for:	multiple-e	employer plan (not multiemployer)	one-participant plan			
В	This return/report is for: first return/report	final retur	n/report				
	an amended return/report	short plar	n year return/report (less than 12 mor	nths)			
С	Check box if filing under:	automatio	extension		☐ DFVC program		
	special extension (enter description	on)					
P	art II Basic Plan Information—enter all requested inform	ation					
-	Name of plan			1b	Three-digit		
	A Brooklyn Woman's Medical Pavilion, P.C				plan number		
	401(k) Plan	4.0	(PN) 001 Effective date of plan				
				10	01/01/2007		
2a	Plan sponsor's name and address (employer, if for single-employer A Brooklyn Womans	plan)		2b	Employer Identification Number		
	A Brooklyn Womans Medical Pavilion, P.C.				(EIN) 11-3446625		
	·			2c	Plan sponsor's telephone number (718) 222-0123		
	44 Court Street			2d	Business code (see instructions)		
	Brooklyn		NY 11201	o - 1 2,0	621111		
За	Plan administrator's name and address (if same as Plan sponsor, e Same	nter "Same	e")	3b	Administrator's EIN		
				3c	Administrator's telephone number		
	f the name and/or EIN of the plan sponsor has changed since the last name, EIN, and the plan number from the last return/report. Sponso		port filed for this plan, enter the	4b	EIN		
	name, Lin, and the plan number from the last returnieport. Sponso	n 3 name		4c	PN		
5a	Total number of participants at the beginning of the plan year			5a	27		
b	Total number of participants at the end of the plan year			5b	0		
С	Total number of participants with account balances as of the end of complete this item)			5c			
62	Were all of the plan's assets during the plan year invested in eligib				X Yes No		
	Are you claiming a waiver of the annual examination and report of	an indeper	ndent qualified public accountant (IQ	PA)	prond forms		
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility				X Yes No		
m.	If you answered "No" to either 6a or 6b, the plan cannot use Fort III Financial Information	orm 5500-	SF and must instead use Form 550	00.			
<u>ге</u> 7	Plan Assets and Liabilities		(a) Beginning of Year	T	(b) End of Year		
-	Total plan assets	. 7a	431,34	7	(b) Liid of Teal		
	Total plan liabilities			0	0		
	Net plan assets (subtract line 7b from line 7a)		431,34	7	0		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total		
а	Contributions received or receivable from:		r 3r				
	(1) Employers	8a(1)	5,75	-			
	(2) Participants	8a(2)	11,55				
la.	(3) Others (including rollovers)	8a(3)	9,73 15,48	0000000			
b	Other income (loss)	8b	10,40	0	42,532		
c d	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		+	12,002		
Ç.	to provide benefits)	. 8d	78	5 .			
е	Certain deemed and/or corrective distributions (see instructions)	8e	33,64				
f	Administrative service providers (salaries, fees, commissions)	8f	5	6			
g	Other expenses	8g		0			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			34,486		
ĺ	Net income (loss) (subtract line 8h from line 8c)			4	8,046		
i	Transfers to (from) the plan (see instructions)	0;	(439.393) [

Form	5500-	SF	201	n

Page	2-	

Pai	t IV Plan Characteristics	MATERIAL CONTROL OF THE PROPERTY OF THE PROPER		***************************************	O TO PERSONAL PROPERTY OF THE PERSONAL PROPERT	inomonos u		Prince and the Contract of the	Name of Street, Street
9a	The state of the s								
b	2E 2F 2G 2J 2K 2T 3D b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:								
Par	V Compliance Questions		alministration of the second s		West Marie Control	жерекулена м	Gircumina de Sinjergolok Kilogo de proposa zama	***************************************	
10	During the plan year:				Yes	No	T	Amount	
а	Was there a failure to transmit to the plan any participant contribution	ons within the time pe	riod described in				† <i>'</i>	Amount	
h	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduc	iary Correction Progra	am)	10a		X			
IJ	Were there any nonexempt transactions with any party-in-interest? on line 10a.)	(Do not include trans	actions reported	10b		Х			
С	Was the plan covered by a fidelity bond?		- t-	10c	$\neg \dashv$		<u> </u>	***************************************	
d	Did the plan have a loss, whether or not reimbursed by the plan's fir or dishonesty?	delity bond, that was	caused by fraud	10d		X X			
е	Were any fees or commissions paid to any brokers, agents, or other insurance service or other organization that provides some or all of instructions.)	r persons by an insur-	ance carrier,	10e		X		2774a	
f	Has the plan failed to provide any benefit when due under the plan?		P			X			
g	Did the plan have any participant loans? (If "Yes," enter amount as		-	10f					
_	If this is an individual account plan, was there a blackout period? (S	•	1	10g		X			
	2520.101-3.)			10h		Х	i si		
İ	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-3			10i					ja Partija
	VI Pension Funding Compliance								
11	Is this a defined benefit plan subject to minimum funding requiremer 5500))	nts? (If "Yes," see inst	ructions and comp	olete S	chedi	ule SE	(Form	Yes	X No
12	Is this a defined contribution plan subject to the minimum funding re							Yes	
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicate If a waiver of the minimum funding standard for a prior year is being granting the waiver. ou completed line 12a, complete lines 3, 9, and 10 of Schedule II	amortized in this plan	Month	tions, a	ınd ei	nter th Day	e date of the	etter ru	ıling
b	Enter the minimum required contribution for this plan year			•••••	. [12b		h	***************************************
C	Enter the amount contributed by the employer to the plan for this pla	n year			. [12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the negative amount)	ne result (enter a minu	us sign to the left o	of a	. [12d			
e	Will the minimum funding amount reported on line 12d be met by the	funding deadline?					Yes	No	N/A
Part	VII Plan Terminations and Transfers of Assets				***************************************				
13a	Has a resolution to terminate the plan been adopted during the plan				- Innered	****		X Yes	No
	If "Yes," enter the amount of any plan assets that reverted to the em	ployer this year		•••••		13a			
	Were all the plan assets distributed to participants or beneficiaries, to of the PBGC?			•••••		ntrol 		X Yes	No
С	If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.)	this plan to another	plan(s), identify the	e plan(s) to			·	
1	3c(1) Name of plan(s):	· · · · · · · · · · · · · · · · · · ·			13c	(2) EI	N(s)	13c(3) PN(s)
A]	Bronx Women's Medical Pavilion 401(k) Plan			04-3785421			0	02	
Sar	Savannah Women's Medical Center, Inc. 401(k) Plan 58-2170360 001					01			
Cauti	on: A penalty for the late or incomplete filing of this return/repor	t will be assessed u	ınless reasonable	caus	e is e	stabl	ished.		
SB or	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule NB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, porrect, and completed.								
SIGN WAR WAN Y NOT 10 4 1 Suzanne Kno:				rr					
HERI		Date	Enter name of ind	dividua	l sign	ing as	plan admin	istrator	
SIGN	r V						7070000 Williams	m-m/NSHEEMEROOM	**************************************
HER		Date	Enter name of ind	lividua	l sign	ing as	employer o	r plan sp	onsor
									