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).

2040

2010

OMB Nos. 1210-0110 1210-0089

This Form is Open to Public Inspection

P	ension Benefit Guaranty Corporation	▶ Complete all entries in accor	dance wit	h the instructions to the Form 550	0-SF.	1							
		dentification Information											
For	For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010												
Α.	This return/report is for:	single-employer plan	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	year return/report (less than 12 mor	nths)								
С	Check box if filing under:	Form 5558	automatio	extension		DFVC program							
	special extension (enter description)												
Da	Part II Basic Plan Information—enter all requested information												
	Name of plan		1h	Three-digit									
	Name of Plan SPRINGS AESTHETIC PLAST	IC SURGERY 401(K) PLAN			10	plan number							
	51 THIT CO THE THE TENOT	10 001102111 101(11) 1 2111				(PN) ▶ 001							
					1c	Effective date of plan							
						01/01/2009							
		ess (employer, if for single-employer	plan)		2b	Employer Identification Number							
THE	SPRINGS AESTHETIC PLAST	TC SURGERY, PC			0-	(EIN) 26-2420332							
115 N	MAPLE STREET				2C	Plan sponsor's telephone number 518-761-9500							
GLE	IS FALLS, NY 12801				2d	Business code (see instructions)							
						621111							
3a	Plan administrator's name and	address (if same as Plan sponsor, e	nter "Same	e")	3b	Administrator's EIN							
THE	SPRINGS AESTHETIC PLAST	TIC SURGERY, PC 115 MAPLE GLENS FALI		301	0 -	26-2420332							
					3C	Administrator's telephone number 518-761-9500							
4	the name and/or FIN of the pla	an sponsor has changed since the la	st return/re	port filed for this plan, enter the	4b	FIN							
		er from the last return/report. Sponso		per med ter and plan, erner are									
					4c	PN							
5a	Total number of participants a	t the beginning of the plan year			5a	6							
b	Total number of participants a	t the end of the plan year			5b	5							
С	Total number of participants w	rith account balances as of the end o	f the plan y	rear (defined benefit plans do not		-							
	complete this item)				5c	5							
	•	during the plan year invested in eligib		,		Yes No							
b		he annual examination and report of (See instructions on waiver eligibility				X Yes ☐ No							
		ner 6a or 6b, the plan cannot use F		•									
Pa	rt III Financial Inform												
7	Plan Assets and Liabilities			(a) Beginning of Year		(b) End of Year							
-	Total plan assets		. 7a	110304	ļ.	240151							
b	. ota. p.a accosto												
C		7b from line 7a)	7c	110304	ļ	240151							
8	Income, Expenses, and Trans		70	(a) Amount		(b) Total							
а	Contributions received or rece			(a) Amount		(b) Total							
<u> </u>			. 8a(1)	76966	5								
	(2) Participants		. 8a(2)	37569)								
	(3) Others (including rollovers	3)		4293	3								
b	, ,	,		11322	2								
С	Total income (add lines 8a(1).	8a(2), 8a(3), and 8b)				130150							
d		rollovers and insurance premiums		000									
			. 8d	303									
е	Certain deemed and/or correct	tive distributions (see instructions)	. 8e										
f	Administrative service provide	rs (salaries, fees, commissions)	. 8f		_								
g	Other expenses		. 8g										
h	Total expenses (add lines 8d,	8e, 8f, and 8g)				303							
i	Net income (loss) (subtract line	e 8h from line 8c)	. 8i			129847							
i		ee instructions)											

	Form 5500-SF 2010 Page 2-				
ar	t IV Plan Characteristics				
a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Chara	acteris	tic Co	des in th	ne instructions:
h	2A 2E 2F 2G 2J 2T 3D If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Chara.	ctarist	ic Coo	les in th	e instructions:
D	in the plan provides wellare benefits, effect the applicable wellare leature codes from the last of half chara-	otorist	10 000	.03 111 111	e mandenona.
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	X		2983
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
С	Was the plan covered by a fidelity bond?	10c		X	
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		Х	
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 com 5500))				
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	RISA? Yes No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)				
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruction granting the waiver				
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				

Part VII | Plan Terminations and Transfers of Assets

Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control 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.)

b Enter the minimum required contribution for this plan year.....

c Enter the amount contributed by the employer to the plan for this plan year......
 d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a

negative amount)

e Will the minimum funding amount reported on line 12d be met by the funding deadline?.....

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

12b

12c

12d

Yes

No

Yes

Yes X No

N/A

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.	10/12/2011	DR. JEFFREY RIDHA						
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator						
SIGN	Filed with authorized/valid electronic signature.	10/12/2011	DR. JEFFREY RIDHA						
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).

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

	Complete all entries in accord	ance with	me msuucu	ons to the rollingsoc	J-31 .					
_	art I Annual Report Identification Information									
For	the calendar plan year 2010 or fiscal plan year beginning	01/01		and ending	12/	31/2010				
Α	This return/report is for: x single-employer plan	multiple-en	nployer plan (r	ot multiemployer)	Ш	one-participant plan				
В	This return/report is for: first return/report	final return	report							
	an amended return/report	short plan	/ear return/rep	oort (less than 12 month	ns) _					
С	Check box if filing under:	automatic e	extension			DFVC program				
	special extension (enter description))								
P	art II Basic Plan Information enter all requested infor	mation.								
1a	Name of plan					hree-digit an number				
	The Springs Aesthetic Plastic Surgery 401(k) P.	lan				PN) ▶ 001				
						ffective date of plan				
_						1/01/2009				
2a	Plan sponsor's name and address (employer, if for single-employer pl. The Springs Aesthetic Plastic Surgery, PC	an)				mployer Identification Number				
	ine springs reschedic reasons surgery, re					lan sponsor's telephone number				
	115 Maple Street					518) 761-9500				
US	Glens Falls NY 12801					usiness code (see instructions) 21111				
3a	, , , ,	ter "Same")			3b A	dministrator's EIN				
	Same									
					3c Administrator's telephone number					
4	If the name and/or EIN of the plan sponsor has changed since the last	plan, enter the	4b EIN							
	name, EIN and the plan number from the last return/report. Sponsor's	Name			4c P	N				
5a	Total number of participants at the beginning of the plan year				5a	6				
b	Total number of participants at the end of the plan year				5b	5				
С	Total number of participants with account balances as of the end of the				5c	5				
6a	complete this item)									
b	Are you claiming a waiver of the annual examination and report of an									
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and	l conditions	.) * * *	or on an an ances of an an		X Yes No				
_	If you answered "No" to either 6a or 6b, the plan cannot use Form	1 5500-SF a	and must inst	ead use Form 5500.						
Pa	art III Financial Information		(a) D	entered of Vers	T	(h) End of Voor				
<i>'</i>	Plan Assets and Liabilities		(a) B	eginning of Year	-	(b) End of Year				
	Total plan assets	7a		110,304	+	240,151				
b	Total plan liabilities	7b		110,304		240,151				
С	Net plan assets (subtract line 7b from line 7a)	7c				0/04/24-04-04-04-04-0				
a a	Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from:		-	(a) Amount		(b) Total				
а	(1) Employers	8a(1)		76,966	4					
	(2) Participants	8a(2)		37,569						
	(3) Others (including rollovers)	8a(3)		4,293	4					
b	Other income (loss)	8b		11,322						
Ç	Total income(add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				130,150				
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	94		303						
е	Certain deemed and/or corrective distributions (see instructions)	8d 8e		505	7					
f	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				303				
ï	Net income (loss) (subtract line 8h from line 8c).	8i				129,847				
i	Transfers to (from) the plan (see instructions)	8j								

8	Form 5500-SF 2010				Page 2-						
Pai	t IV Plan Characteristics										-
9a	If the plan provides pension benefits, enter the applicable pension fea	ature	codes fro	m the Li	st of Plan Characteris	stic Co	des i	n the ir	nstructions:		
b	2A 2E 2F 2G 2J 2T 3D if the plan provides welfare benefits, enter the applicable welfare feat	ture c	odes from	the lie	of Plan Characterist	ic Cor	lee in	the inc	trustione		
	in the plant provides wellare benefits, effect the applicable wellare feat	rare (Jodes IIOII	I IIIA LIS	or Flam Characterist	IC COL	195 111	the m	structions:		
Pai	t V Compliance Questions										
10	During the plan year:						Yes	No		Amount	
司	Was there a failure to transmit to the plan any participant contribution	ion w	ithin the ti	me perio	d described in	10a	x				2,98
b	29 CFR 2510.3-102? (See Instructions and DOL's Voluntary Fiduci Were there any nonexempt transactions with any party-in-interest?					108	-				
	on line 10a.)					10b		x	ļ		
C	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 fi or dishonesty?					10d		x			
•						100	-		-		
e	Were any fees or commisions paid to any brokers, agents, or other insurance services or other organization that provides some or all or	of the	benefits (ınder the	plan? (See			x			
£	instructions.)					10e		200			_
f	Has the plan failed to provide any benefit when due under the plan?					10f		Х			
9	Did the plan have any participant loans? (If "Yes," enter amount as	•	,			10g		x			
h	If this is an individual account plan, was there a blackout period? (S 2520.101-3.)	See ir	structions		CFR	10h		x			
i	If 10h was answered "Yes," check the box if you either provided the	e requ	uired notic								
Darl	exceptions to providing the notice applied under 29 CFR 2520.101- VI Pension Funding Compliance	3 .			· · · · · · ·	10i		_			
11	Is this a defined benefit plan subject to minimum funding requirement	nts?	(If "Yes,"	see instr	uctions and complete	Sche	dule	SB (Fo	ern		X No
12	ls this a defined contribution plan subject to the minimum funding re					netion	202.4	4 EDIO	A? .	-	X No
_	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applica			3000011	TIZ OF THE CODE OF SE	Calon	002 0	CLINIC	· ·		[BE] 100
а	If a waiver of the minimum funding standard for a prior year is being			his plan	vear, see instructions	s. and	enter	the da	ate of the lef	tter rulina	
	granting the waiver ou completed line 12a, complete lines 3, 9, and 10 of Schedule N				Mon						
ь	Enter the minimum required contribution for this plan year	•			-		. r	12b			
С	Enter the amount contributed by the employer to the plan for this pla						. [12c			-
đ	Subtract the amount in line 12c from the amount in line 12b. Enter the	-				51 15		12d		11	
_	negative amount)						·	country.			
e art	Will the minimum funding amount reported on line 12d be met by the		ding dead	line?		• •			Yes	No	N/A
	The state of the s									- IV	₩.
Jä	Has a resolution to terminate the plan been adopted during the plan if "Yes," enter the amount of any plan assets that reverted to the em	year	or any pr	ior year'		• •	ÌĖ		• • •	. Lites	[X]NO
Ь	Were all the plan assets distributed to participants or beneficiaries, to	_					-1	13a			
	of the PBGC?	ıransı	erred to a	nother p	ian, or prougnt unde	runeo	ontro	٠		. Yes	X No
C	If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.)	n this	plan to a	nother pl	an(s), identify the pla	ın(s) te	0				
1:	c(1) Name of plan(s):						13	c(2) E	IN(s)	13c(3)	PN(s)
								-1-/	(0)	145(0	11(0)
	A could find be a large with a first					_					
	: A penalty for the late or Incomplete filing of this return/report										_
3 or S	enalties of perjury and other penalties set forth in the instructions, I on the dule MB completed and signed by an enrolled actuary, as well, as is true, correct, and complete.										
SIGN			10/12	vi	Dr. Jeffrey I	Ridh	a .				
HERE	Signature of plan administrator	_	ate	·W	Enter name of indiv			N 90 7	lan adminis	strator	
SIGN		1				- raudi	Jigilli	as h	an equilina	i di Gi	
HERE	Signature of employer/plan sponsor	-	ate		Enter name of indiv	idust	elanie	m ne -	molever	nlan erer	or
A THE STATE OF	1 8 or or his of or biggs about or		uic.		True name or mor	Ibuuii	angi III	A 92 6	mployer of	Man abous	VI.

Schedule H, Line 4

Schedule of Delinquent Participant Contributions

For the Plan Year Beginning	01/01/2010	_ and Ending	12/31/	/2010			
Name of Plan: The Springs	Aesthetic Plast	ic Surgery	401(k) F	Plan			
Employer Identification Number:	26-2420332			Three-digit	olan number:	001	

Participant Contributions Transferred Late to Plan	Total that Cons	tituta Nanayamat Brahihitad 7	Francastiana	
Check here if Late	i otal that Cons	titute Nonexempt Prohibited	Tansaciions	Total Fully Corrected
	On a fall and an a Mari	Contributions Commented	On a talk of the angle of the angle	Under VFCP and PTE
Participant Loan	Contributions Not	Contributions Corrected	Contributions Pending	2002-51
Repayments are	Corrected	Outside VFCP	Correction in VFCP	
included:				
\$2,983		+	\$2,983	\$2,983
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		+		
		I	1	l

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Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

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_	art I Annual Report Identification Information									
For	the calendar plan year 2010 or fiscal plan year beginning	01/01		and ending	12/	31/2010				
Α	This return/report is for: x single-employer plan	multiple-en	nployer plan (r	ot multiemployer)	Ш	one-participant plan				
В	This return/report is for: first return/report	final return	report							
	an amended return/report	short plan	/ear return/rep	oort (less than 12 month	ns) _					
С	Check box if filing under:	automatic e	extension			DFVC program				
	special extension (enter description))								
P	art II Basic Plan Information enter all requested infor	mation.								
1a	Name of plan					hree-digit an number				
	The Springs Aesthetic Plastic Surgery 401(k) P.	lan				PN) ▶ 001				
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_						1/01/2009				
2a	Plan sponsor's name and address (employer, if for single-employer pl. The Springs Aesthetic Plastic Surgery, PC	an)				mployer Identification Number				
	ine springs rescheded reasons surgery, re					lan sponsor's telephone number				
	115 Maple Street					518) 761-9500				
US	Glens Falls NY 12801					usiness code (see instructions) 21111				
3a	, , , ,	ter "Same")			3b A	dministrator's EIN				
	Same									
					3c Administrator's telephone number					
4	If the name and/or EIN of the plan sponsor has changed since the last	plan, enter the	4b EIN							
	name, EIN and the plan number from the last return/report. Sponsor's	Name			4c P	N				
5a	Total number of participants at the beginning of the plan year				5a	6				
b	Total number of participants at the end of the plan year				5b	5				
С	Total number of participants with account balances as of the end of the				5c	5				
6a	complete this item)									
b	Are you claiming a waiver of the annual examination and report of an									
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and	l conditions	.) * * *	or on an an ances of an an		X Yes No				
_	If you answered "No" to either 6a or 6b, the plan cannot use Form	1 5500-SF a	and must inst	ead use Form 5500.						
Pa	art III Financial Information		(a) D	entered of Vers	Т —	(h) End of Voor				
<i>'</i>	Plan Assets and Liabilities		(a) B	eginning of Year	-	(b) End of Year				
	Total plan assets	7a		110,304	+	240,151				
b	Total plan liabilities	7b		110,304		240,151				
С	Net plan assets (subtract line 7b from line 7a)	7c				0/04/24-04-04-04-04-0				
a a	Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from:		-	(a) Amount		(b) Total				
а	(1) Employers	8a(1)		76,966	4					
	(2) Participants	8a(2)		37,569						
	(3) Others (including rollovers)	8a(3)		4,293	4					
b	Other income (loss)	8b		11,322						
Ç	Total income(add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				130,150				
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	94		303						
е	Certain deemed and/or corrective distributions (see instructions)	8d 8e		505	7					
f	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				303				
ï	Net income (loss) (subtract line 8h from line 8c).	8i				129,847				
i	Transfers to (from) the plan (see instructions)	8j								

8	Form 5500-SF 2010				Page 2-						
Pai	t IV Plan Characteristics										-
9a	If the plan provides pension benefits, enter the applicable pension fea	ature	codes fro	m the Li	st of Plan Characteris	stic Co	des i	n the ir	nstructions:		
b	2A 2E 2F 2G 2J 2T 3D if the plan provides welfare benefits, enter the applicable welfare feat	ture c	odes from	the lie	of Plan Characterist	ic Cor	lee in	the inc	trustione		
	in the plant provides wellare benefits, effect the applicable wellare feat	rare (Jodes IIOII	I IIIA LIS	or Flam Characterist	IC COL	195 111	the m	structions:		
Pai	t V Compliance Questions										
10	During the plan year:						Yes	No		Amount	
司	Was there a failure to transmit to the plan any participant contribution	ion w	ithin the ti	me perio	d described in	10a	x				2,98
b	29 CFR 2510.3-102? (See Instructions and DOL's Voluntary Fiduci Were there any nonexempt transactions with any party-in-interest?					108	-				
	on line 10a.)					10b		x	ļ		
C	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 fi or dishonesty?					10d		x			
•						100	-		-		
e	Were any fees or commisions paid to any brokers, agents, or other insurance services or other organization that provides some or all or	of the	benefits (ınder the	plan? (See			x			
£	instructions.)					10e		200			_
f	Has the plan failed to provide any benefit when due under the plan?					10f		Х			
9	Did the plan have any participant loans? (If "Yes," enter amount as	•	,			10g		x			
h	If this is an individual account plan, was there a blackout period? (S 2520.101-3.)	See ir	structions		CFR	10h		x			
i	If 10h was answered "Yes," check the box if you either provided the	e requ	uired notic								
Darl	exceptions to providing the notice applied under 29 CFR 2520.101- VI Pension Funding Compliance	3 .			· · · · · · ·	10i		_			
11	Is this a defined benefit plan subject to minimum funding requirement	nts?	(If "Yes,"	see instr	uctions and complete	Sche	dule	SB (Fo	ern		X No
12	ls this a defined contribution plan subject to the minimum funding re					nation	202.4	4 EDIO	A? .	-	X No
_	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applica			3000011	TIZ OF THE CODE OF SE	Calon	002 0	CLINIC	· ·		[BE] 100
а	If a waiver of the minimum funding standard for a prior year is being			his plan	vear, see instructions	s. and	enter	the da	ate of the lef	tter rulina	
	granting the waiver ou completed line 12a, complete lines 3, 9, and 10 of Schedule N				Mon						
ь	Enter the minimum required contribution for this plan year	•			-		. r	12b			
С	Enter the amount contributed by the employer to the plan for this pla						. [12c			-
đ	Subtract the amount in line 12c from the amount in line 12b. Enter the	-				51 15		12d		11	
_	negative amount)						·	country.			
e art	Will the minimum funding amount reported on line 12d be met by the		ding dead	line?		• •			Yes	No	N/A
	The state of the s									- IV	₩.
Jä	Has a resolution to terminate the plan been adopted during the plan if "Yes," enter the amount of any plan assets that reverted to the em	year	or any pr	ior year'		• •	ÌĖ		• • •	. Lites	[X]NO
h	Were all the plan assets distributed to participants or beneficiaries, to	_					-1	13a			
	of the PBGC?	ıransı	erred to a	nother p	ian, or prougnt unde	runeo	ontro	٠		. Yes	X No
C	If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.)	n this	plan to a	nother pl	an(s), identify the pla	ın(s) te	0				
1:	c(1) Name of plan(s):						13	c(2) E	IN(s)	13c(3)	PN(s)
								-1-/	(0)	145(0	11(0)
	A could find be a large with a first					_					
	: A penalty for the late or Incomplete filing of this return/report										_
3 or S	enalties of perjury and other penalties set forth in the instructions, I on the dule MB completed and signed by an enrolled actuary, as well, as is true, correct, and complete.										
SIGN			10/12	vi	Dr. Jeffrey I	Ridh	a .				
HERE	Signature of plan administrator	_	ate	·W	Enter name of indiv			N 90 7	lan adminis	strator	
SIGN		1				- raudi	Jigill	as h	an equilina	i di Gi	
HERE	Signature of employer/plan sponsor	-	ate		Enter name of indiv	idust	elanie	m ne -	molever	nlan erer	or
A THE STATE OF	1 8 or or his of or biggs about or		uic.		True name or mor	Ibuuii	angi III	A 92 6	mployer of	Man abous	VI.