Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee 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

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 07/01/2008 and ending 03/31/2009

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [X] the final return/report;
- [X] an amended return/report;
- [X] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SLR MEDICAL ANESTHESIOLOGY PC 401(K) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 07/01/1991

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
SLR MEDICAL ANESTHESIOLOGY PC

1111 AMSTERDAM AVE
NEW YORK, NY 10025

1111 AMSTERDAM AVE
NEW YORK, NY 10025

2b Employer Identification Number (EIN)
13-3590672

2c Sponsor's telephone number
212-523-2500

2d Business code (see instructions)
621111

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 accompanying schedules, statements and attachments, 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 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
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SLR MEDICAL ANESTHESIOLOGY PC

1111 AMSTERDAM AVE
NEW YORK, NY 10025

3b Administrator's EIN
13-3590672

3c Administrator's telephone number
212-523-2500

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a 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

9b Plan benefit arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** ☐ **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 Information) - signed by the plan actuary

b General Schedules

- **(1)** ☐ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ ___ **A** (Insurance Information)
- **(4)** ☐ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of 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 sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

Official Use Only
OMB Nos. 1210-0110
1210-0089

2008 800902

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning 07/01/2008, and ending 03/31/2009.

A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify) ____

B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☒ the final return/report filed for the plan;
(2) ☒ an amended return/report; (4) ☒ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ▶ ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan
SLR MEDICAL ANESTHESIOLOGY, P.C.
401(K) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan (mo., day, yr.) 07/01/1991

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
SLR MEDICAL ANESTHESIOLOGY, P.C.

1111 AMSTERDAM AVENUE

NEW YORK NY 10025

2b Employer Identification Number (EIN) 13-3590672

2c Sponsor's telephone number 212-523-2500

2d Business code (see instructions) 621111

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

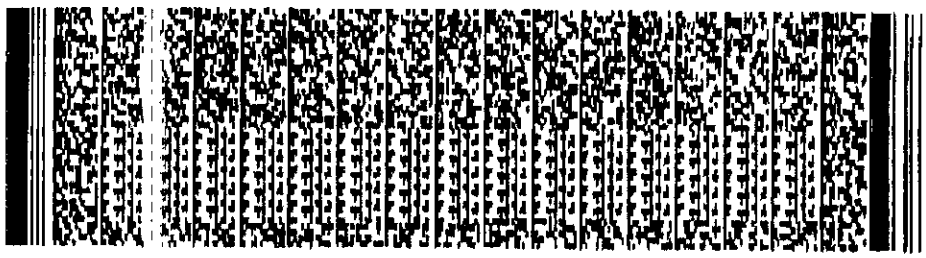
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

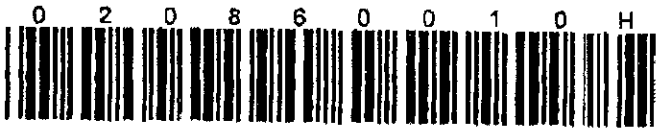
Sign Here

Signature of plan administrator — Date — DANIEL THYS — Type or print name of individual signing as plan administrator

Sign Here

Signature of employer/plan sponsor/DFE — Date — DANIEL THYS — Type or print name of individual signing as employer, plan sponsor or DFE





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3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SAME	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/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: a Sponsor's name	b EIN c PN
5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN c Telephone number

6	Total number of participants at the beginning of the plan year	6 75
7	Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	
a	Active participants	7a 0
b	Retired or separated participants receiving benefits	7b 0
c	Other retired or separated participants entitled to future benefits	7c 0
d	Subtotal. Add lines 7a, 7b, and 7c	7d 0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e 0
f	Total. Add lines 7d and 7e	7f 0
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g 0
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h 0
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2E 2F 2G 2J

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) [ ] Insurance	(1) [ ] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	(3) [X] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor

0 2 0 8 6 0 0 2 0 1

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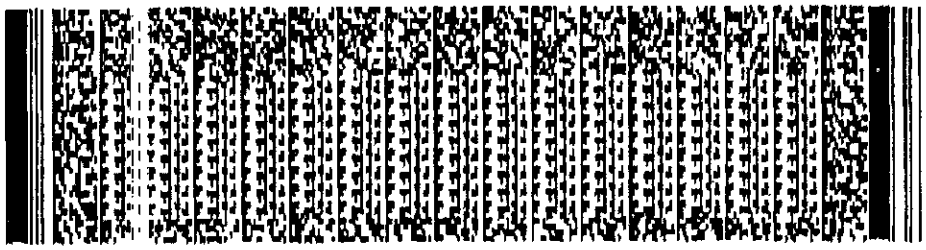
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) [X] R (Retirement Plan Information)
- (2) [ ] B (Actuarial Information)
- (3) [ ] E (ESOP Annual Information)
- (4) [ ] SSA (Separated Vested Participant Information)

b Financial Schedules

- (1) [ ] H (Financial Information)
- (2) [X] I (Financial Information -- Small Plan)
- (3) [ ] A (Insurance Information)
- (4) [ ] C (Service Provider Information)
- (5) [ ] D (DFE/Participating Plan Information)
- (6) [ ] G (Financial Transaction Schedules)



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.

Official Use Only

OMB No. 1210-0110

2008

This Form is Open to Public Inspection.

For calendar year 2008 or fiscal plan year beginning 07/01/2008 and ending 03/31/2009

A Name of plan	B Three-digit plan number ▶
SLR MEDICAL ANESTHESIOLOGY, P.C. 401(K) PLAN	002

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number
SLR MEDICAL ANESTHESIOLOGY, P.C.	13-3590672

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.

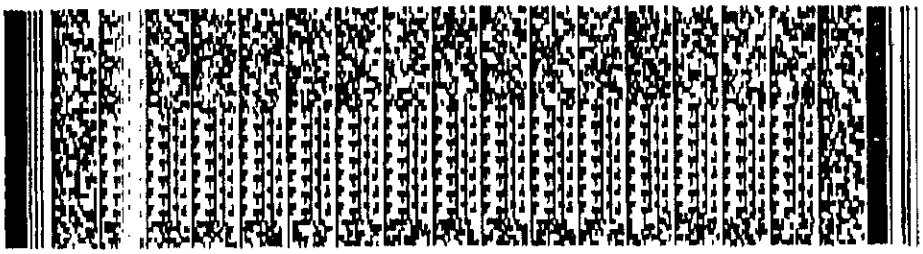
Part I Small Plan Financial Information

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.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	21290940	0
b	Total plan liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	21290940	0
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable			
	(1) Employers	2a(1)	0	
	(2) Participants	2a(2)	339050	
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	2b		
c	Other income	2c	-4867138	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		-4528088
e	Benefits paid (including direct rollovers)	2e	1049334	
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Other expenses	2h	85	
i	Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		1049419
j	Net income (loss) (subtract line 2i from line 2d)	2j		-5577507
k	Transfers to (from) the plan (see instructions)	2k		-15713433

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 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
a	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	



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			Yes	No	Amount
3c	Real estate other than employer real property)	3c		X	
d	Employer s curities	3d		X	
e	Participant ans	3e		X	
f	Loans (oth than to participants)	3f		X	
g	Tangible p sonal property	3g		X	

Part III Transactions During Plan Year

			Yes	No	Amount
4	During the an year:				
a	Did the em oyer fail to transmit to the plan any participant contributions within the time period des ibed in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction rogram.)	4a		X	
b	Were any l ns by the plan or fixed income obligations due the plan in default as of the close of th plan year or classified during the year as uncollectible? Disregard participant loans secu d by the participant's account balance	4b		X	
c	Were any l ses to which the plan was a party in default or classified during the year as uncollectib ?	4c		X	
d	Were there ny nonexempt transactions with any party-in-interest? (Do not include transaction reported on line 4a.)	4d		X	
e	Was the pl covered by a fidelity bond?	4e	X		500000
f	Did the pla have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by aud or dishonesty?	4f		X	
g	Did the pla hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the pla receive any noncash contributions whose value was neither readily determina on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the pla at any time hold 20% or more of its assets in any single security, debt, mortgage, arcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all th plan assets either distributed to participants or beneficiaries, transferred to another pl , or brought under the control of the PBGC?	4j	X		
k	Are you cl ming a waiver of the annual examination and report of an independent qualified public acc untant (IQPA) under 29 CFR 2520.104-46? If no, attach an IQPA's report or 2520.104-) statement. (See instructions on waiver eligibility and conditions.)	4k	X		

5a Has a resc ution 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 he employer this year ☐ Yes ☒ No Amount

5b If during th 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 trans rred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)
WESTSI E ANESTHESIOLOGY, PC 401(K)	26-3082143	001

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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 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).

▶ File as an Attachment to Form 5500.

OMB No. 1210-0110

2008

This Form is Open to Public Inspection.

For calendar year 2008 or fiscal plan year beginning 07/01/2008 and ending 03/31/2009

A Name of plan: SLR MEDICAL ANESTHESIOLOGY, P.C. 401(K) PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500: SLR MEDICAL ANESTHESIOLOGY, P.C.

D Employer Identification Number: 13-3590672

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . 1 $ 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the plan year (If more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-3183640

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 plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

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 7.

5 If a waiver of the minimum funding standard for a prior plan year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver . . . . . ▶ Month ____ Day ____ Year ____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6a 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 $

If you completed line 6c, skip lines 7 and 8 and complete line 9.

7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☐ N/A

Part III Amendments

8 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. (See instructions.) ☐ Increase ☐ Decrease ☐ No

Part IV Coverage (See Instructions.)

9 Check the box for the test this plan used to satisfy the coverage requirements	ratio percentage test	average benefit test

2 2 0 8 6 0 0 1 0 J