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| 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 |
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| | | | |
|--------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------|
| Part I | Annual Report Identification Information | | |
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008 | | | |
| A This return/report is for: | <input type="checkbox"/> a multiemployer plan; | <input type="checkbox"/> a multiple-employer plan; or | |
| | <input checked="" type="checkbox"/> a single-employer plan; | <input type="checkbox"/> a DFE (specify) ____ | |
| B This return/report is: | <input type="checkbox"/> the first return/report; | <input checked="" type="checkbox"/> the final return/report; | |
| | <input type="checkbox"/> an amended return/report; | <input type="checkbox"/> a short plan year return/report (less than 12 months). | |
| C If the plan is a collectively-bargained plan, check here. | <input type="checkbox"/> | | |
| D Check box if filing under: | <input type="checkbox"/> Form 5558; | <input type="checkbox"/> automatic extension; | <input type="checkbox"/> the DFVC program; |
| | <input type="checkbox"/> special extension (enter description) | | |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------|--|
| Part II | Basic Plan Information —enter all requested information | | |
| 1a Name of plan MEDIACAST LLC PROFIT SHARING PLAN | 1b Three-digit plan number (PN) ► | 001 | |
| | 1c Effective date of plan | 12/31/1999 | |
| 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) MEDIA CAST LLC 19 STUYVESANT OVAL STE 1A NEW YORK, NY 10009 | 2b Employer Identification Number (EIN) | 13-3974296 | |
| | 2c Sponsor's telephone number | 212-529-3584 | |
| | 2d Business code (see instructions) | 541800 | |
| | | | |

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") MEDIA CAST LLC 19 STUYVESANT OVAL STE 1A NEW YORK, NY 10009 | 3b Administrator's EIN 13-3974296 3c Administrator's telephone number 212-529-3584 |
| 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) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | 9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> 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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

13-3974296 P

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

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2008
or fiscal plan year beginning

and ending

- 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

MEDIACAST LLC PROFIT SHARING PLAN

Three-digit plan number (PN) ►

001

1c Effective date of plan

12 31 1999

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.

Signature of plan administrator

SIGN HERE ►

Type or print name of individual signing as plan administrator

Date

07 29 2011

a. MARK D ROFFMAN

Signature of employer/plan sponsor/DFE

SIGN HERE ►

Type or print name of individual signing as employer, plan sponsor or DFE

Date



For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500. Cat. No. 13500F Form 5500 (2008)



v11.3

5 Preparer information (optional)**a** Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year **2****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 **0****b** Retired or separated participants receiving benefits **0****c** Other retired or separated participants entitled to future benefits **0****d** Subtotal. Add lines **7a**, **7b**, and **7c** **0****e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits **0****f** Total. Add lines **7d** and **7e** **0****g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) **0****h** Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested **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) **0**

0 1 0 8 0 0 0 3 0 C



**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 the calendar plan year 2008
or fiscal plan year beginning

and ending

A Name of plan

MEDICAST, LLC PROFIT SHARING PLAN

B Three-digit
plan number

► *001*

C Plan sponsor's name as shown on line 2a of Form 5500

MEDICAST, LLC

D Employer Identification Number

13 3974296

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 | <i>35286</i> | <i>00</i> |
| b Total plan liabilities | <i>0</i> | <i>0</i> |
| c Net plan assets (subtract line 1b from line 1a) | <i>35286</i> | <i>0</i> |
| 2 Income, Expenses, and Transfers for this Plan Year: | (a) Amount | |
| a Contributions received or receivable | | |
| (1) Employers | <i>0</i> | |
| (2) Participants | <i>0</i> | |
| (3) Others (including rollovers) | <i>0</i> | |
| b Noncash contributions | <i>0</i> | |
| c Other income | <i>0</i> | |
| | | (b) Total |
| d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) | | <i>0</i> |

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1 9 0 8 0 0 0 1 0 J



| | Yes | No | Amount |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| 4d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) | | X | |
| e Was the plan covered by a fidelity bond? | | X | |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | 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? | | 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? | | 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? | | 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? | 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 an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.) | | X | |

| | Yes | No | Amount |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| 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 | X | | |

5b 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

5b(2) EIN

5b(3) PN

5b(1) Name of plan

5b(2) EIN

5b(3) PN

5b(1) Name of plan

5b(2) EIN

5b(3) PN



(a) Amount

2e Benefits paid (including direct rollovers)

35 286

f Corrective distributions (see instructions)

0

g Certain deemed distributions of participant loans
(see instructions)

0

h Other expenses

0

(b) Total

i Total expenses (add lines 2e, 2f, 2g, and 2h)

35 286

j Net income (loss) (subtract line 2i from line 2d)

- 35 286

k Transfers to (from) the plan (see instructions)

0

3 Specific Assets: If the plan held assets at any time 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 |
|---------------------------------------------------------|-----|----|--------|
| a Partnership/joint venture interests | | X | |
| b Employer real property | | X | |
| c Real estate (other than employer real property) | | X | |
| d Employer securities | | X | |
| e Participant loans | | X | |
| f Loans (other than to participants) | | X | |
| g Tangible personal property | | X | |

X

X

X

X

X

X

X

Part II Transactions During Plan Year

4 During the plan year:

| | Yes | No | Amount |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| a Did the employer fail 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.) | | X | |
| b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance | | X | |
| c Were any leases to which the plan was a party in default or classified during the year as uncollectible? | | X | |

X

X

X

1 9 0 8 0 0 0 2 0 K



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

- a** ☒ Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

1 A

- b** Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed 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 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)**a Pension Benefit Schedules**

- 1) **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) ☒ **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)

0 1 0 8 0 0 0 4 0 D



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

1) MEDIACAST LLC
19 STUYVESANT OVAL SUITE 1A
2) C/O NEW YORK NY 10009

3)

4)

5)

6)

7)

8)

9)

2b Employer Identification Number (EIN)

13 3974296

212 529 3584

2d Business code

(see instructions) 541800

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C / O

3)

4)

5)

6)

7)

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

SAME

b EIN

c PN

