

<b>Form 5500-SF</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b>  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).  <b>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2010</div>  <b>This Form is Open to Public Inspection</b>
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<b>Part I Annual Report Identification Information</b>			
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>12/31/2010</u>			
<b>A</b> This return/report is for:	<input checked="" type="checkbox"/> single-employer plan	<input type="checkbox"/> multiple-employer plan (not multiemployer)	<input type="checkbox"/> one-participant plan
<b>B</b> This return/report is for:	<input type="checkbox"/> first return/report	<input type="checkbox"/> final return/report	
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> short plan year return/report (less than 12 months)	
<b>C</b> Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input checked="" type="checkbox"/> DFVC program
	<input type="checkbox"/> special extension (enter description)		

<b>Part II Basic Plan Information</b> —enter all requested information			
<b>1a</b> Name of plan <u>ORAL &amp; MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C. CASH BALANCE PLAN</u>	<b>1b</b> Three-digit plan number (PN) ▶	<u>003</u>	
	<b>1c</b> Effective date of plan	<u>01/01/2003</u>	
<b>2a</b> Plan sponsor's name and address (employer, if for single-employer plan) <u>ORAL &amp; MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C.</u>  <u>41 EAST 57TH STREET, SUITE 1204</u> <u>NEW YORK, NY 10022</u>	<b>2b</b> Employer Identification Number (EIN)	<u>13-3789526</u>	
	<b>2c</b> Plan sponsor's telephone number	<u>212-593-0303</u>	
	<b>2d</b> Business code (see instructions)	<u>621210</u>	
<b>3a</b> Plan administrator's name and address (if same as Plan sponsor, enter "Same") <u>ORAL &amp; MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C.</u> <u>41 EAST 57TH STREET, SUITE 1204</u> <u>NEW YORK, NY 10022</u>	<b>3b</b> Administrator's EIN	<u>13-3789526</u>	
	<b>3c</b> Administrator's telephone number	<u>212-593-0303</u>	
<b>4</b> 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. Sponsor's name	<b>4b</b> EIN		
	<b>4c</b> PN		
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b>	<u>9</u>	
<b>b</b> Total number of participants at the end of the plan year .....	<b>5b</b>	<u>9</u>	
<b>c</b> Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) .....	<b>5c</b>		
<b>6a</b> Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<b>b</b> Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.</b>			

<b>Part III Financial Information</b>			
<b>7</b> Plan Assets and Liabilities		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	<u>367607</u>	<u>403082</u>
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	<u>367607</u>	<u>403082</u>
<b>8</b> Income, Expenses, and Transfers for this Plan Year		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>		
<b>(2)</b> Participants .....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>	<u>38879</u>	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		<u>38879</u>
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .....	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>		
<b>g</b> Other expenses .....	<b>8g</b>	<u>3404</u>	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		<u>3404</u>
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		<u>35475</u>
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

**Part IV Plan Characteristics****9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

1A 1C 1I

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

		Yes	No	Amount
<b>10</b> During the plan year:				
<b>a</b> 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) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>	X		55000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> 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.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> 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 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500)) ..... ☒ Yes ☐ No

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .. ☐ Yes ☒ No  
(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)

**a** 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 letter ruling granting the waiver. .... Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.**

<b>b</b> Enter the minimum required contribution for this plan year .....	<b>12b</b>	
<b>c</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>12c</b>	
<b>d</b> 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) .....	<b>12d</b>	

**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 year or any prior year? ..... ☒ Yes ☐ No  
If "Yes," enter the amount of any plan assets that reverted to the employer this year ..... **13a** 0

**b** Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ..... ☐ Yes ☒ No

**c** 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)

**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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	01/09/2012	CONNIE SCHNABEL
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  ▶ <b>File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2010</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>ORAL &amp; MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C. CASH BALANCE PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶ <u>003</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>ORAL &amp; MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C.</u>	<b>D</b> Employer Identification Number (EIN) <u>13-3789526</u>
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

<b>Part I</b>	<b>Basic Information</b>
<b>1</b>	Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2010</u>
<b>2</b>	Assets:
<b>a</b>	Market value ..... <b>2a</b> <u>367599</u>
<b>b</b>	Actuarial value ..... <b>2b</b> <u>367599</u>
<b>3</b>	Funding target/participant count breakdown
	(1) Number of participants (2) Funding Target
<b>a</b>	For retired participants and beneficiaries receiving payment ..... <b>3a</b> <u>0</u> <u>0</u>
<b>b</b>	For terminated vested participants ..... <b>3b</b> <u>4</u> <u>11381</u>
<b>c</b>	For active participants:
(1)	Non-vested benefits ..... <b>3c(1)</b> <u>0</u>
(2)	Vested benefits ..... <b>3c(2)</b> <u>328370</u>
(3)	Total active ..... <b>3c(3)</b> <u>5</u> <u>328370</u>
<b>d</b>	Total ..... <b>3d</b> <u>9</u> <u>339751</u>
<b>4</b>	If the plan is at-risk, check the box and complete items (a) and (b) ..... <input type="checkbox"/>
<b>a</b>	Funding target disregarding prescribed at-risk assumptions ..... <b>4a</b>
<b>b</b>	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor ..... <b>4b</b>
<b>5</b>	Effective interest rate ..... <b>5</b> <u>6.73</u> %
<b>6</b>	Target normal cost ..... <b>6</b> <u>0</u>

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	<u>08/08/2011</u>
Signature of actuary	Date
<u>MICHAEL C. GUNVALSON</u>	<u>11-04266</u>
Type or print name of actuary	Most recent enrollment number
<u>LURIE BESIKOF LAPIDUS &amp; CO, LLP</u>	<u>612-377-4404</u>
Firm name	Telephone number (including area code)
<u>2501 WAYZATA BLVD.</u> <u>MINNEAPOLIS, MN 55405</u>	
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

**For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.**

**Schedule SB (Form 5500) 2010**  
**v.092308.1**

Part II	Beginning of year carryover and prefunding balances	(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year) .....	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year) .....	0	0
9	Amount remaining (Item 7 minus item 8).....	0	0
10	Interest on item 9 using prior year's actual return of <u>16.53</u> % .....		
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year) .....		0
b	Interest on (a) using prior year's effective rate of <u>6.11</u> % .....		0
c	Total available at beginning of current plan year to add to prefunding balance .....		0
d	Portion of (c) to be added to prefunding balance.....		
12	Reduction in balances due to elections or deemed elections.....	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12).....	0	0

Part III	Funding percentages		
14	Funding target attainment percentage.....	<b>14</b>	108.19 %
15	Adjusted funding target attainment percentage.....	<b>15</b>	108.19 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	<b>16</b>	73.17 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	<b>17</b>	%

Part IV	Contributions and liquidity shortfalls				
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
<b>Totals ►</b>			<b>18(b)</b>	0	<b>18(c)</b>
				0	

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:			
a Contributions allocated toward unpaid minimum required contribution from prior years.....	<b>19a</b>		0
b Contributions made to avoid restrictions adjusted to valuation date .....	<b>19b</b>		0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	<b>19c</b>		0
20 Quarterly contributions and liquidity shortfalls:			
a Did the plan have a "funding shortfall" for the prior year? ..... <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ..... <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
c If 20a is "Yes," see instructions and complete the following table as applicable:			
Liquidity shortfall as of end of Quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

**Part V Assumptions used to determine funding target and target normal cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 5.03 %	2nd segment: 6.73 %	3rd segment: 6.82 %	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code) .....				<b>21b</b> 4
<b>22</b> Weighted average retirement age .....				<b>22</b> 62
<b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

**Part VI Miscellaneous items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>27</b> If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment.....	<b>27</b>

**Part VII Reconciliation of unpaid minimum required contributions for prior years**

<b>28</b> Unpaid minimum required contribution for all prior years .....	<b>28</b>	12416
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a).....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (item 28 minus item 29) .....	<b>30</b>	12416

**Part VIII Minimum required contribution for current year**

<b>31</b> Target normal cost, adjusted, if applicable (see instructions).....	<b>31</b>	0
<b>32</b> Amortization installments:	Outstanding Balance	Installment
<b>a</b> Net shortfall amortization installment .....	0	0
<b>b</b> Waiver amortization installment .....	0	0
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>	
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33).....	<b>34</b>	0
	Carryover balance	Prefunding balance
<b>35</b> Balances used to offset funding requirement .....	0	0
<b>36</b> Additional cash requirement (item 34 minus item 35).....	<b>36</b>	0
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c).....	<b>37</b>	0
<b>38</b> Interest-adjusted excess contributions for current year (see instructions).....	<b>38</b>	0
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37).....	<b>39</b>	0
<b>40</b> Unpaid minimum required contribution for all years .....	<b>40</b>	12416

**Schedule SB, line 22**  
**Description of Weighted Average Retirement Age**

Plan: Oral & Maxillofacial Surgery Associates of Manhattan, P.C. Cash Balance Plan  
EIN/PN: 13-3789526/003

<u>Age</u>	<u>Assumed Rate</u>	<u>Weighted Age</u>
62	100.00%	62.0
		62.0

The assumed rate of retirement is adjusted for the assumed prior retirements and multiplied by the expected retirement age. The resulting amounts are summed to develop the weighted average.

**Schedule SB, Part V**  
**Statement of Actuarial Assumptions/Methods**

Plan: Oral & Maxillofacial Surgery Associates of Manhattan, P.C. Cash Balance Plan  
EIN/PN: 13-3789526/003

Salary Scale: None

Retirement Assumption: Participants assumed to retire on their Normal Retirement Date as defined in the Plan

Withdrawal Rates: None

Mortality Table Used: Combined mortality tables for small plans

Assumed Form of Distribution:

Life Annuity	0%
Lump Sum	100%

## **Schedule SB, Part V**

### **Summary of Plan Provisions**

Plan: Oral & Maxillofacial Surgery Associates of Manhattan, P.C. Cash Balance Plan  
EIN/PN: 13-3789526/003

#### **Employer and Plan Data**

Initial Effective Date	January 1, 2003
Plan Year Begins	January 1, 2010
Plan Year Ends	December 31, 2010
Valuation Date	January 1, 2010

#### **Eligibility Requirements**

Service	One year
Entry Dates	Dual
Age	21
Excluded Groups	Associate Doctors, Collectively Bargained, Non-Resident Alien, Employees of Affiliated Employers, Independent Contractors

#### **Normal Retirement Age**

First of the month following the attainment of Age 62.

#### **Retirement Benefits**

Actuarial Equivalent of the Participant's Hypothetical Account Balance.

#### **Hypothetical Account**

A theoretical account that is maintained for each participant. Each account is credited annually with interest at the 30 Year Treasury Bill rate in effect for the fifth month prior to the Plan Year plus contributions based on the schedule in the Plan document.

#### **Vesting**

100% vested upon completion of 3 years of Vesting Service excluding Years of Service accumulated prior to Age 18 and prior to the Plan's Effective Date.

#### **Death**

100% of the Participant's Hypothetical Account.

#### **Disability**

100% of the Participant's Hypothetical Account.

#### **Plan Amendments**

The plan froze all benefit accruals as of May 31, 2009.

## SB ACTUARY SIGNATURE

<b>SCHEDULE SB</b> <b>(Form 5500)</b> <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2010</b>  <b>This Form is Open to Public Inspection</b>
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>12/31/2010</u>		

► Round off amounts to nearest dollar.

► Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan  <u>Oral &amp; Maxillofacial Surgery Associates of Manhattan, PC CB Plan</u>	<b>B</b> Three-digit plan number (PN) <u>003</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF  <u>Oral &amp; Maxillofacial Surgery Associates of Manhattan, P.C.</u>	<b>D</b> Employer Identification Number (EIN)  <u>13-3789526</u>
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B <input type="checkbox"/> Other <b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

<b>Part I Basic Information</b>			
<b>1</b> Enter the valuation date: Month <u>1</u> Day <u>1</u> Year <u>2010</u>			
<b>2</b> Assets:			
a Market value.....	<b>2a</b>	367,599	
b Actuarial value.....	<b>2b</b>	367,599	
<b>3</b> Funding target/participant count breakdown			
		(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment .....	<b>3a</b>	0	0
b For terminated vested participants .....	<b>3b</b>	4	11,381
c For active participants:			
(1) Non-vested benefits.....	<b>3c(1)</b>		0
(2) Vested benefits.....	<b>3c(2)</b>		328,370
(3) Total active .....	<b>3c(3)</b>	5	328,370
d Total.....	<b>3d</b>	9	339,751
<b>4</b> If the plan is at-risk, check the box and complete items (a) and (b) <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor.....	<b>4b</b>		
<b>5</b> Effective interest rate .....	<b>5</b>	6.73 %	
<b>6</b> Target normal cost.....	<b>6</b>	0	

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	 Signature of actuary <u>Michael C. Gunvalson</u> Type or print name of actuary <u>Lurie Besikof Lapidus &amp; Co, LLP</u> Firm name <u>2501 Wayzata Blvd.</u> <u>Minneapolis</u> <u>MN 55405</u> Address of the firm	<u>08/08/2011</u> Date <u>11-04266</u> Most recent enrollment number <u>(612) 377-4404</u> Telephone number (including area code)
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2010  
v.092308.1

**Part II Beginning of year carryover and prefunding balances**

	(a) Carryover balance	(b) Prefunding balance
<b>7</b> Balance at beginning of prior year after applicable adjustments (Item 13 from prior year) .....	0	0
<b>8</b> Portion used to offset prior year's funding requirement (Item 35 from prior year) .....	0	0
<b>9</b> Amount remaining (Item 7 minus item 8) .....	0	0
<b>10</b> Interest on item 9 using prior year's actual return of <u>16.53</u> % .....		
<b>11</b> Prior year's excess contributions to be added to prefunding balance:		
<b>a</b> Excess contributions (Item 38 from prior year) .....		0
<b>b</b> Interest on (a) using prior year's effective rate of <u>6.11</u> % .....		0
<b>c</b> Total available at beginning of current plan year to add to prefunding balance .....		0
<b>d</b> Portion of (c) to be added to prefunding balance .....		
<b>12</b> Reduction in balances due to elections or deemed elections .....	0	0
<b>13</b> Balance at beginning of current year (item 9 + item 10 + item 11d - item 12) .....	0	0

**Part III Funding percentages**

<b>14</b> Funding target attainment percentage .....	<b>14</b>	108.19 %
<b>15</b> Adjusted funding target attainment percentage .....	<b>15</b>	108.19 %
<b>16</b> Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement .....	<b>16</b>	73.17 %
<b>17</b> If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage .....	<b>17</b>	%

**Part IV Contributions and liquidity shortfalls**

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
<b>Totals ▶</b>			<b>18(b)</b>	0	<b>18(c)</b> 0

**19** Discounted employer contributions - see instructions for small plan with a valuation date after the beginning of the year:

<b>a</b> Contributions allocated toward unpaid minimum required contribution from prior years. ....	<b>19a</b>	0
<b>b</b> Contributions made to avoid restrictions adjusted to valuation date .....	<b>19b</b>	0
<b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....	<b>19c</b>	0

**20** Quarterly contributions and liquidity shortfalls:

**a** Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No

**b** If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No

**c** If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

**Part V Assumptions used to determine funding target and target normal cost**

<b>21</b>	Discount rate:			
<b>a</b>	Segment rates:	1st segment: 5.03 %	2nd segment: 6.73 %	3rd segment: 6.82 %
		<input type="checkbox"/> N/A, full yield curve used		
<b>b</b>	Applicable month (enter code) .....			<b>21b</b> 4
<b>22</b>	Weighted average retirement age .....			<b>22</b> 62
<b>23</b>	Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute			

**Part VI Miscellaneous items**

<b>24</b>	Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b>	Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b>	Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>27</b>	If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment. ....	<b>27</b>

**Part VII Reconciliation of unpaid minimum required contributions for prior years**

<b>28</b>	Unpaid minimum required contribution for all prior years .....	<b>28</b>	12,416
<b>29</b>	Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a) .....	<b>29</b>	0
<b>30</b>	Remaining amount of unpaid minimum required contributions (item 28 minus item 29) .....	<b>30</b>	12,416

**Part VIII Minimum required contribution for current year**

<b>31</b>	Target normal cost, adjusted, if applicable (see instructions) .....	<b>31</b>	0
<b>32</b>	Amortization installments:	Outstanding Balance	Installment
<b>a</b>	Net shortfall amortization installment .....	0	0
<b>b</b>	Waiver amortization installment .....	0	0
<b>33</b>	If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>	
<b>34</b>	Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b - item 33) .....	<b>34</b>	0
<b>35</b>	Balances used to offset funding requirement .....	Carryover balance	Prefunding balance
		0	0
<b>36</b>	Additional cash requirement (item 34 minus item 35) .....	<b>36</b>	0
<b>37</b>	Contributions allocated toward minimum required contribution for current year adjusted to valuation date (item 19c) .....	<b>37</b>	0
<b>38</b>	Interest-adjusted excess contributions for current year (see instructions) .....	<b>38</b>	0
<b>39</b>	Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37) .....	<b>39</b>	0
<b>40</b>	Unpaid minimum required contribution for all years .....	<b>40</b>	12,416

<b>Form 5500-SF</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b>  This form is required to be filed under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <b>2010</b>  <b>This Form is Open to Public Inspection</b>
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**Part I Annual Report Identification Information**

For calendar plan year 2010 or fiscal plan year beginning		01/01/2010	and ending	12/31/2010
A This return/report is for:	<input checked="" type="checkbox"/> single-employer plan	<input type="checkbox"/> multiple-employer plan (not multiemployer)	<input type="checkbox"/> one-participant plan	
B This return/report is for:	<input type="checkbox"/> first return/report	<input type="checkbox"/> final return/report		
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> short plan year return/report (less than 12 months)		
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program	
	<input type="checkbox"/> special extension (enter description)			

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan Oral & Maxillofacial Surgery Associates of Manhattan, P.C. Cash Balance Plan	<b>1b</b> Three-digit plan number (PN)	003
	<b>1c</b> Effective date of plan	01/01/2003
<b>2a</b> Plan sponsor's name and address (employer, if for single-employer plan) Oral & Maxillofacial Surgery Associates of Manhattan, P.C.  41 East 57th Street, Suite 1204  New York NY 10022	<b>2b</b> Employer identification number (EIN) 13-3789526  <b>2c</b> Plan sponsor's telephone number (212) 593-0303  <b>2d</b> Business code (see instructions) 621210	
<b>3a</b> Plan administrator's name and address (if same as Plan sponsor, enter "Same") Same	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number	
<b>4</b> 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. Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN	
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b>	9
<b>b</b> Total number of participants at the end of the plan year.....	<b>5b</b>	9
<b>c</b> Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).....	<b>5c</b>	
<b>6a</b> Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>b</b> Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.).....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

**Part III Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets .....	7a	367,607	403,082
<b>b</b> Total plan liabilities .....	7b		
<b>c</b> Net plan assets (subtract line 7b from line 7a).....	7c	367,607	403,082
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers .....	8a(1)		
(2) Participants .....	8a(2)		
(3) Others (including rollovers).....	8a(3)		
<b>b</b> Other income (loss).....	8b	38,879	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	8c		38,879
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	8d		
<b>e</b> Certain deemed and/or corrective distributions (see instructions).....	8e		
<b>f</b> Administrative service providers (salaries, fees, commissions).....	8f		
<b>g</b> Other expenses.....	8g	3,404	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		3,404
<b>i</b> Net income (loss) (subtract line 8h from line 8c).....	8i		35,475
<b>j</b> Transfers to (from) the plan (see instructions) .....	8j		

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500-SF.

Form 5500-SF (2010)  
v.092308.1

Form 5500-SF 2010

Page 2-  **Part IV Plan Characteristics**

**9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
1A 1C 1T

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

**Part V Compliance Questions**

10	During the plan year:	Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-1027 (See instructions and DOL's Voluntary Fiduciary Correction Program) .....		X	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....		X	
c	Was the plan covered by a fidelity bond? .....	X		55,000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....		X	
e	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.) .....		X	
f	Has the plan failed to provide any benefit when due under the plan? .....		X	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....		X	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....		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. ....			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500))..... ☒ Yes ☐ No

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .. ☐ Yes ☒ No  
(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)

**a** 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 letter ruling granting the waiver. .... Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

**b** Enter the minimum required contribution for this plan year..... **12b** \_\_\_\_\_

**c** 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 a negative amount) .....

**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 year or any prior year? ..... ☒ Yes ☐ No  
If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a** \_\_\_\_\_ 0

**b** Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?..... ☐ Yes ☒ No

**c** 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)

**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.

<b>SIGN HERE</b>	<i>John B. Todorovich, Pres.</i>	1-5-12	John B. Todorovich
	Signature of plan administrator.	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	<i>John B. Todorovich, Pres.</i>	1-5-12	John B. Todorovich
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor