Form 5500	Annual Return/Report of Employee Be	1210-0089			
Department of the Treasury Internal Revenue Service					
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 	2009			
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection			
Part I Annual Report Ider	tification Information				
For calendar plan year 2009 or fiscal	plan year beginning 07/01/2008	and ending 06/30/2009			
A This return/report is for:	a multiemployer plan; a multiple-emplo	yer plan; or			
·	a single-employer plan; a DFE (specify)				
B This return/report is:	the first return/report; the final return/re	eport;			
	an amended return/report; a short plan year return/report (less than 12 months).				
C If the plan is a collectively-bargain	ed plan, check here				
D Check box if filing under:	Form 5558; automatic extens				
	special extension (enter description)				
Part II Basic Plan Inform	nation—enter all requested information				
1a Name of plan	C DEFINED BENEFIT PLAN AND TRUST	1b Three-digit plan number (PN) ▶ 002			
		1c Effective date of plan 07/01/2007			
2a Plan sponsor's name and addres (Address should include room or season of the season		2b Employer Identification Number (EIN) 20-0268899			
		2c Sponsor's telephone number			
6 HELEN DR ROSLYN HEIGHTS, NY 11577	6 HELEN DR ROSLYN HEIGHTS, NY 11577	2d Business code (see instructions)			

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			
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Page 2

	Plan administrator's name and address (if same as plan sponsor, enter "Same") ST HILLS MEDICAL SERVICES PC		ministrator's EIN 0268899
	HELEN DR DSLYN HEIGHTS, NY 11577		ministrator's telephone mber
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 the plan number from the last return/report:	and	4b EIN
а	Sponsor's name		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).		
а	Active participants	6a	
b	Retired or separated participants receiving benefits	. 6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a , 6b , and 6c	. 6d	
е	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:

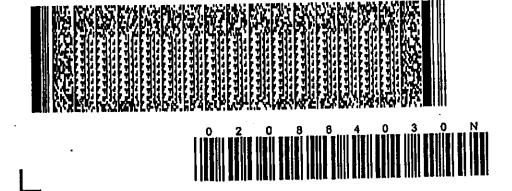
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a	Plan fu	n <u>ding</u>	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)		Trust		(3)		Trust				
	(4)		General assets of the sponsor		(4)		General assets of the sponsor				
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are a	0 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										
а	Pensio	n Sc	hedules	b	General	Scł	hedules				
а	Pensio (1)	n Sci	hedules R (Retirement Plan Information)	b	General (1)	Sci	hedules H (Financial Information)				
а		n Sci		b		Scl					
а	(1)	n Sci	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1)	ScI	H (Financial Information)				
а	(1)	n Sci	R (Retirement Plan Information)MB (Multiemployer Defined Benefit Plan and Certain Money	b	(1) (2)	Scl	H (Financial Information)I (Financial Information – Small Plan)				
а	(1)	in Sci	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	b	(1) (2) (3)		 H (Financial Information) I (Financial Information – Small Plan) A (Insurance Information) 				

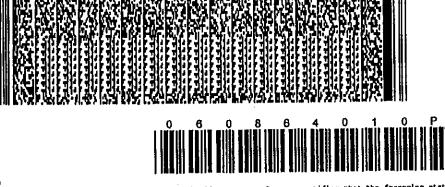
From 5500 Annual Return/Report of Employee Benefit Plan Image: Comparison of the Employee Benefit Plan The form is required to be find under sections 104 and 4055 of the Employee Benefit Plan Image: Comparison of the Employee Benefit Plan The section and the comparison of the Complex of the Compl	r				1		
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(2) □ an amended return/report; (a) □ a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check hera		(2) 🕅 a single-employer	plan (other than a				
D If Bling under an extension of time or the DFVC program, check box and attach required information. (see instructions)	B This return/report is:	· · · ·		• • H			n 12 months <u>).</u>
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Characteristics Codes printed in the instructions): (4.B)		hand hand
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	n 412(e)(3) insuranc	e contracts
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(4) General assets of the sponsor (4) General asset	ee of the sponsor	
	n Min	_
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ľ,	Form 5500		Page 3 Official Use Only
10 a	Schedules attac Pension Benefi (1) X (2) (3) (4)	hed (Check all applicable boxes and, where indicated t Schedules R (Retrement Plan Information) B (Actuarial Information) E (ESOP Annual Information) SSA (Separated Vested Participant Information)	a. enter the number attached. See instructions.) b Financial Schedules (1) H (Financial Information) (2) I (Financial Information) (3) X 1 A (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information) (6) G (Financial Transaction Schedules)



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(Form	•	1			ar section 104 of	the	L L	OMB	No. 1210-0110		
Department o	l the Treasury onue Service	Employee	e Retirement	Income Secu	rity Act of 1974.			2008			
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Employee Benefits Se Pension Benefit Ge			mpanies are recent to Fi	required to p	rovide this inform 03(a)(2).	auo	1	Pub	lic Inspection.		
			07/01/2		and endin	g	06/30	/2009			
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EAST HILLS	MEDICAL	SERV PC DB					plan numl		2	<u>.</u>	
C Plan sponsor's EAST HILLS		n on line 2a of Form 5500				D	Employer	identifi	cation Number 20-0268899)	
report 1 Coverage:	ted on a single	Schadule A.		·······							
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(b) EIN	(c) NAIC code	(d) Contract or identification number	(8) A covered	pproximata nu 1 at end of poi	mber of persons icy or contract yes	ar	(1) F		(g) To		
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2 Insurance fees brokers and oth	and commissioner persons inc	ons paid to agents, brokers a lividually in descending order	of the amou	int paid in the	e total fees and to items on the folio	tal e wiл	commission g page(s) in	s below n Part I.	and list agents,		
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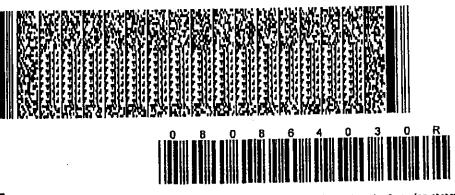
National Sife Insurance Company certifies that the foregoing statement is::complete and accurate based on information in our insurance records.

	2008	Page 2	Official Use Only
	(a) Name and	address of the agents, brokers or other	
OWARD LESTER POLANSK	Y	whom commissions or fees were paid	
ND FLOOR 733 3RD AVE EW YORK	NY	10017-3204	
(b) Amount of			(e)
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		NON-MONETARY COMPENSATION	
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n na	(a) Name and :	address of the agents, brokers or other	
	persons to w	whom commissions or fees were paid	
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	(a) Name and	address of the agents, brokers or other	
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Schedule A (Form 5500) 2008	Page 3
	Official Use Only
Bartell Investment and Annuity Contract Information	
Where individual contracts are provided, the entire group of such individ	lual contracts with each carrier may be treated as a unit for
purposes of this report.	
3 Current value of plan's interest under this contract in the general account at year er	nd
4 Current value of plan's interest under this contract in separate accounts at year end	d
5 Contracts With Allocated Funds	1 · · · · · · · · · · · · · · · · · · ·
8 State the basis of premium rates ► BASED ON SCHEDULES FILED W	/STATE 14022
b Premiums paid to carrier	
C Premiums due but unpaid at the end of the year	
d If the carrier, service, or other organization incurred env specific costs in connecti	ion with the acquisition
or retention of the contract or policy, enter amount	·····
Specity nature of costs >	
e Type of contrect (1) individual policies (2) group deferred annuity	y .
(3) 🔲 other (specify) 🕨	D
f If contract purchased, in whole or in part, to distribute benefits from a terminating	g plan check here
6 Contracts With Unallocated Funds (Do not include portions of these contracts mi	aintainsd in separate accounts)
	diate participation guarantee
(3) U guaranteed investment (4) U othsr	(specify below)
►	
b Balance at the and of the previous year	0
C Additions: (1) Contributions deposited during the year	
(2) Dividends and credits.	0
(3) interest credited during the year	
(4) Transferred from separate account	0
(5) Other (specify below)	
(6) Total additions di Total of balance and additions (add b and c(6))	
 Deductions: (1) Disbureed from fund to pay benefits or purchase annulties during year 	0
 Dispureed from tund to pay benefits of purchase annulues county you	0
(2) Administration charge made by camer	0
(3) Transferred to separate account	0
(4) Unter (specity delow)	
(5) Total deductions,	-
 (5) Total deductions. f Balance at the end of the current year (subtract e(5) from d). 	



National Life insurance Company certifies that the foregoing statement is:complete and accurate based on information in our insurance records.

		employee organization(as a unit, Where individ	a), the information ri lual contracts are pr	nay ovid	be combined for reportir led, the entire group of s	ng purposes if such (uch individual contra	contracts are exp acts with each ce	mier may be
		treated as a unit for pur			• • • • • • • • • • • • • • • • • • •			
	_	t and contract type (check a				——————————————————————————————————————		al 🗖 1 K - Innuneana
		lealth (other than dental or		ън	Dental		unemployment	d Life Insurance
	-	remporary disability (accide) Stop loss (large daductible)		Η	Long-term disability HMO contract	g Supplementa k PPO contract	• •	I Indemnity cont
	н	Dither (specify)	· 1	ч	HIVIO CONVACI	K [] [] O contract		, (), · · · ·
	_	ence-rated contracts	······································					
		ums: (1) Amount received					0	
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		erned ((1) + (2) - (3))						and the second strategy of the States
b :		charges: (1) Claims paid					0	
		crease (decrease) in claim r					0	
		curred claims (add (1) and						
		laims charged					,	
C		nder of premium: (1) Retent	-				0	
) Commissions					0	
	•	3) Administrative service or					0	
		C) Other specific acquisition					0	
		Other expenses					o	
	(E	E) Taxes					0	
	(P) (P)	 Charges for risks or other Other retention charges 	-				0	
		 Other retention charges Total retention 					P	
	(2) (2)	ividends or retroactive rate i	refunds. (These em	ບານ ຄຸມກາ	a were 🗍 paid in cash.	or Credited.)		
d :	Status 4	of policyholder reserves at	end of year: (1) Am	ouni	held to provide benefits	after retirement		
	(2) Cl	laim reserves						
	(3) Of	ther reserves					· • • • • • • • • • • • • • • • • • • •	
e	Dividen	nds or retroactive rate refun	ds due. (Do not inci	iude	amount entered in c(2).)		a sheeph of the children of the second
	Nonexp	perience-rated contracts:						
a	Total pi	remiums or subscription ch	arges paid to carrie	r.,			·····	
		arrier, service, or other orga						
		ntion of the contract or polic	cy, other than report	ted i	n Part I, item 2 above, re	port amount		
;	Spacify	y nature of costs ►						
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			Official Use O	niy
SCHEDULE R	Retirement Pian information		OMB No. 1210	-0110
(Form 5500)	This schedule is required to be filed under sections 104 and 4065	i of the		
Oepartment of the Treasury Internal Revenue Service	Consigure Detirement income Security Act of 1974 (ChigA) Bit action	on 6058(a)	2008	
Construction of Labor	of the Internal Revenue Code (the Code).		This Form is C	pen lo
Employee Benefits Security Administration Pension Bunefit Guaranty Corporation	File as an Attachment to Form 5500.		Public Inspe	ction.
For calendar year 2008 or fiscal pla	an year beginning 07/01/2008 , and ending		/30/2009	<u>t</u>
A Nemo of plan		B Three-di	-	002
EAST HILLS MEDICAL S	ERVICES PC DEFINED BENEFIT PLAN	pian nun	er Identification Nu	mber
C Plan eponsor's name as show	n on line 2a of Form 5500	C Current	20-0	268899
EAST HILLS MEDICAL S	SERVICES PC			
Distributions	is relate only to payments of benefits during the plan year.			
1 Tetal value of distributions pal	d in property other than in cash or the forms of property specified		_	
to the test with the			6 Silaning and the second second	N. Michael
7 Enter the Eikligh of payoris) W	he easid herefits on behalf of the plan to participants or beneficianes our	ing and a		
the plan year (if more than two	o, enter EINs of the two payors who paid the greatest dollar amounts of		동일법 위험을 가지지 않는 같은 것은 것은 것을 가지지 않는	
benefits).				
Profit-sharing plane, ESOPa	, and stock benus plans, skip line 3.			
3 Number of participants (living	sr deceased) whose bensits were distributed in a single sum, during	3		0
the plan year	tation (If the plan is not subject to the minimum funding requirements	of section 412	of the Internal Rev	8016
	u and the this Doct			
4 is the plan administrator maki	ing an election under Code section 412(d)(2) or ERISA section 302(d)(2)	17		ل
if the clan is a defined beni	with plan, ge to line 7.			
	nding standard for e prior plan year is being amortized in this	. ► Month		Ysar
pian year, ses instructions, a	nd enter the date of the ruling latter granting the waiver	mainder of th	is schedule.	
it you completed line 5, con	contribution for this plan year	<u>6a</u>		
فيعارز والمؤسسين السيبينين والارتبار والمراجع	the the empirication in the plan for USS gluin year	····	\$	
 Culture the emount in fine 6 	b from the amount in line 6a. Enter the result (alkel a manual sign is the			
of a recalive amount)			<u></u>	
			natic	
		th the change	7. Yes 1	lo X N/A
approval for the change sr a	class ruling letter, does the plan sponsor or plan administrator agree with			······································
Rendments	nsion plan, were any amendments edopted during this plan year that			
8 If this is a defined benefit pe	value of benefits? If yes, check the appropriate box(es). If no, check the	— .		ASE X NO
"No" box (See instructions.)			ease Decre	230 1.1110
REALING ON ON COMPANY		teen lett	average	benefit test
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For Paperwerk Reduction Act	Notice and OMB Control Numbers, see the instructions for Form 55			
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