

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2011</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information		
For calendar plan year 2011 or fiscal plan year beginning <u>01/01/2011</u> and ending <u>12/31/2011</u>		
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer) <input type="checkbox"/> a one-participant plan
B This return/report is:	<input type="checkbox"/> the first return/report	<input 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 Check box if filing under:	<input 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		
1a Name of plan <u>EAST MANHATTAN MEDICAL SERVICES, PC DEFINED BENEFIT PENSION PLAN</u>	1b Three-digit plan number (PN) ►	<u>001</u>
	1c Effective date of plan	<u>01/01/2010</u>
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>EAST MANHATTAN MEDICAL SERVICES, PC</u> <u>3 EAST 83RD STREET, 2ND FLR.</u> <u>NEW YORK, NY 10028</u>	2b Employer Identification Number (EIN) <u>26-4809837</u>	
	2c Sponsor's telephone number <u>212-734-3444</u>	
	2d Business code (see instructions) <u>621111</u>	
3a Plan administrator's name and address (if same as plan sponsor, enter "Same") <u>EAST MANHATTAN MEDICAL SERVICES, PC</u> <u>3 EAST 83RD STREET, 2ND FLR.</u> <u>NEW YORK, NY 10028</u>	3b Administrator's EIN <u>26-4809837</u>	
	3c Administrator's telephone number <u>212-734-3444</u>	
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	
5a Total number of participants at the beginning of the plan year	5a	8
b Total number of participants at the end of the plan year.....	5b	8
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item).....	5c	
6a 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 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		
If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.		

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	269349	635520
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a).....	7c	269349	635520
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	408000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers).....	8a(3)	0	
b Other income (loss).....	8b	-41829	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		366171
d Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	8d	0	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses.....	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		0
i Net income (loss) (subtract line 8h from line 8c).....	8i		366171
j Transfers to (from) the plan (see instructions)	8j	0	

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 3D

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
10 During the plan year:			
a 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)		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		100000
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)	12d	

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

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.

SIGN HERE	Filed with authorized/valid electronic signature.	04/05/2012	PETER DISTLER
	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

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information 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). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

▶ **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.

A Name of plan <u>EAST MANHATTAN MEDICAL SERVICES, PC DEFINED BENEFIT PENSION PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>EAST MANHATTAN MEDICAL SERVICES, PC</u>	D Employer Identification Number (EIN) <u>26-4809837</u>
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

Part I	Basic Information
1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2011</u>	
2 Assets:	
a Market value	2a <u>227520</u>
b Actuarial value	2b <u>227520</u>
3 Funding target/participant count breakdown:	
	(1) Number of participants (2) Funding Target
a For retired participants and beneficiaries receiving payment	3a <u>0</u> <u>0</u>
b For terminated vested participants	3b <u>1</u> <u>691</u>
c For active participants:	
(1) Non-vested benefits	3c(1) <u>194206</u>
(2) Vested benefits	3c(2) <u>102562</u>
(3) Total active	3c(3) <u>7</u> <u>296768</u>
d Total	3d <u>8</u> <u>297459</u>
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)	<input type="checkbox"/>
a Funding target disregarding prescribed at-risk assumptions	4a
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b
5 Effective interest rate	5 <u>5.25 %</u>
6 Target normal cost	6 <u>291913</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.

SIGN HERE	<u>03/06/2012</u>
Signature of actuary	Date
<u>ED STEINMETZ, E.A.</u>	<u>11-04803</u>
Type or print name of actuary	Most recent enrollment number
<u>ELITE PENSION CONSULTANTS</u>	<u>845-354-8373</u>
Firm name	Telephone number (including area code)
<u>58 MARINER WAY</u> <u>MONSEY, NY 10952</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) 2011
v.012611

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 (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of _____ %		
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38 from prior year)		0
b Interest on (a) using prior year's effective rate of <u>6.06</u> % except as otherwise provided (see instructions)		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		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding percentages		
14 Funding target attainment percentage	14	76.48 %
15 Adjusted funding target attainment percentage	15	38.60 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	0.00 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

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
06/27/2011	300000	0			
02/27/2012	108000	0			
			Totals ►	18(b)	408000
				18(c)	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 contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	408000
20 Quarterly contributions and liquidity shortfalls:		
a Did the plan have a "funding shortfall" for the prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? <input 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

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

21 Discount rate:				
a Segment rates:	1st segment: 1.99%	2nd segment: 5.12%	3rd segment: 6.24 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)				21b 0
22 Weighted average retirement age				22 60
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

Part VI Miscellaneous items

24 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
25 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
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	291913	
b Excess assets, if applicable, but not greater than 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	69939	11051	
b Waiver amortization installment	0	0	
33 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	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)...	34	302964	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....			0
36 Additional cash requirement (line 34 minus line 35)	36	302964	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	408000	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	105036	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years.....	40	0	

Part IX Pension funding relief under Pension Relief Act of 2010 (see instructions)

41 If a shortfall amortization base is being amortized pursuant to an alternative amortization schedule:			
a Schedule elected	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
b Eligible plan year(s) for which the election in line 41a was made	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

EAST MANHATTAN MEDICAL SERVICES, PC

DEFINED BENEFIT PENSION PLAN

Schedule of Active Participant Data

Plan Year: 1/1/2011 to 12/31/2011

Valuation Date: 12/31/2011

Age/ Svc	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Total
0	0	0	0	0	0	0	0	0	0	0	0	0
1-4	1	1	0	0	3	2	0	0	0	0	0	7
5-9	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0	0	0	0	0
15-19	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0	0	0
30-34	0	0	0	0	0	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0	0	0	0	0	0
40+	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	1	0	0	3	2	0	0	0	0	0	7

*Employees who have not met the minimum eligibility requirements are excluded

Average Age: 39.0

Average Service: 2

EAST MANHATTAN MEDICAL SERVICES, PC
DEFINED BENEFIT PENSION PLAN

Statement of Actuarial Assumptions and Method

Plan Year: 1/1/2011 to 12/31/2011

Valuation Date: 12/31/2011

	<u>For PPA Funding</u>	<u>For 417(e)</u>	<u>For Actuarial Equiv.</u>
Interest Rates	Segment 1 1.99%	Pre-Retirement 5.00%	Pre-Retirement 5.00%
	Segment 2 5.12%	Post-Retirement 5.00%	Post-Retirement 5.00%
	Segment 3 6.24%		
Pre-Retirement			
Turnover	None	None	None
Mortality	None	None	None
Assumed Ret Age	Normal retirement age 60 and 5 years of participation	Normal retirement age 60 and 5 years of participation	Normal retirement age 60 and 5 years of participation
Future Salary Increase	5% SALARY SCALE	None	None
Post-Retirement			
Mortality	Male-modified RP2000 combined healthy male projected 23 & 15 yrs Female-modified RP2000 combined healthy female projected 23 & 15 yrs	2008 Applicable Mortality Table from Rev Rul 2006-67	GAR 94 without loads projected to 2002 with scale AA 50%M/50%F
Assumed Benefit Form For Funding		Lump Sum	
Calculated Effective Interest Rate		5.25%	

An actuarial value of assets is used for funding purposes. This year the actuarial value of assets is 100.0% of the market value of assets.

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Short Form Annual Return/Report of Small Employee
Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**OMB Nos. 1210-0110
1210-0089**2011****This Form is Open to Public
Inspection****Part I Annual Report Identification Information**

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

- A** This return/report is for: ☒ a single-employer plan ☐ a multiple-employer plan (not multiemployer) ☐ a one-participant plan
- B** This return/report is: ☐ the first return/report ☐ the final return/report
☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
- C** Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ DFVC program
☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan East Manhattan Medical Services, PC Defined Benefit Pension Plan	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan 01/01/2010
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) East Manhattan Medical Services, PC 3 East 83rd Street, 2nd Flr. New York NY 10028	2b Employer Identification Number (EIN) 26-4809837
	2c Sponsor's telephone number 212-734-3444
	2d Business code (see instructions) 621111
3a Plan administrator's name and address (if same as plan sponsor, enter "Same") East Manhattan Medical Services, PC 3 East 83rd Street, 2nd Flr. New York NY 10028	3b Administrator's EIN 26-4809837
	3c Administrator's telephone number 212-734-3444
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
5a Total number of participants at the beginning of the plan year	5a 8
b Total number of participants at the end of the plan year	5b 8
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c
6a 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 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

If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	269349	635520
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	269349	635520
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	408000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	-41829	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		366171
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	0	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		0
i Net income (loss) (subtract line 8h from line 8c)	8i		366171
j Transfers to (from) the plan (see instructions)	8j	0	

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 3D
- 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 2510.3-102? (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		100000
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) **12d** _____

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

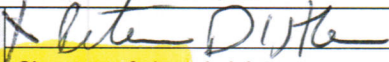

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

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.

SIGN HERE			PETER DISTLER
	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

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information 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). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

► **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.

A Name of plan East Manhattan Medical Services, PC Defined Benefit Pension Plan	B Three-digit plan number (PN) 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF East Manhattan Medical Services, PC	D Employer Identification Number (EIN) 26-4809837
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

Part I Basic Information

1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2011</u>	
2	Assets:	
	a Market value	227520
	b Actuarial value	227520
3	Funding target/participant count breakdown:	
		(1) Number of participants (2) Funding Target
a	For retired participants and beneficiaries receiving payment	0
b	For terminated vested participants	691
c	For active participants:	
	(1) Non-vested benefits	194206
	(2) Vested benefits	102562
	(3) Total active	296768
d	Total	297459
4	If the plan is in at-risk status, check the box and complete lines (a) and (b) <input type="checkbox"/>	
	a Funding target disregarding prescribed at-risk assumptions	4a
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b
5	Effective interest rate	5.25%
6	Target normal cost	291913

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.

SIGN HERE	 Signature of actuary	<u>3/6/2012</u> Date
	ED STEINMETZ, E.A. Type or print name of actuary	1104803 Most recent enrollment number
	ELITE PENSION CONSULTANTS Firm name	845-354-8373 Telephone number (including area code)
	58 MARINER WAY MONSEY NY 10952 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) 2011
v.012611

Equity Investment as of end of quarter of company year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

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

21 Discount rate:			
a Segment rates:	1st segment: 1.99%	2nd segment: 5.12%	3rd segment: 6.24%
			<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)	21b		0
22 Weighted average retirement age	22		60
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute			

Part VI Miscellaneous items

24 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
25 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
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment	27

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	291913	
b Excess assets, if applicable, but not greater than 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	69939	11051	
b Waiver amortization installment	0	0	
33 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	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) ..	34	302964	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0
36 Additional cash requirement (line 34 minus line 35)	36	302964	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	408000	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	105036	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension funding relief under Pension Relief Act of 2010 (see instructions)

41 If a shortfall amortization base is being amortized pursuant to an alternative amortization schedule:			
a Schedule elected	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
b Eligible plan year(s) for which the election in line 41a was made	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

East Manhattan Medical Services, PC Defined Benefit Pension Plan

Tax ID No. 26 - 4809837

Plan Year 01/01/2011 – 12/31/2011

Schedule SB, Line 22 – Description of Weighted Avg. Ret. Age

Rate of retirement at age 60: 100%

East Manhattan Medical Services, PC Defined Benefit Pension Plan

Tax ID No. 26 – 4809837

Plan Year 01/01/2010 – 12/31/2010

Schedule SB, Line 32 – Schedule of Amortization Bases

The type of base is shortfall, not waiver.

The present value of any remaining installments is (incl. the installment for the current p/y) is \$69,939.

The base was established as of December 31, 2011.

6 years remain in the amortization period.

The amortization installment is \$11,051.