## 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).

1210-0089

OMB Nos. 1210-0110

2011

This Form is Open to Public Inspection

	Complete all entries in accord	aance witi	the instructions to the Form 55	)0-5F.		
Pa	art I Annual Report Identification Information					
For	calendar plan year 2011 or fiscal plan year beginning 01/01/201	1	and ending	12/31/2	011	
Α .	This return/report is for: $\overline{\mathbb{X}}$ a single-employer plan $\Box$	a single-employer plan a multiple-employer plan (not multiemployer) a one-participant plan				
В	This return/report is: the first return/report	the final re	eturn/report			
	an amended return/report	a short pla	n year return/report (less than 12 n	nonths)		
С	Check box if filing under: X Form 5558	automatic	extension	Ī	DFVC program	
	special extension (enter descriptio			L	_ ' "	
Do		,				
		ation		1h	Thurs disit	
	Name of plan  SISLAND CARDIOLOGY ASSOCIATES, LLP 401K PROFIT SHARI	NG DI AN			Three-digit plan number	
LOIVE	SIDEAND CARDIOLOGI ACCOCIATEC, ELI 40TRI ROTTI CHART	INO I LAIN			(PN) ▶ 001	
				1c	Effective date of plan	
					01/01/1999	
2a	Plan sponsor's name and address; include room or suite number (en	mployer, if	for a single-employer plan)	2b	Employer Identification Number	
LON	G ISLAND CARDIOLOGY ASSOCIATES, LLP			-	(EIN) 11-3433397	
				2c	Sponsor's telephone number	
	SILLS ROAD, BUILDING 14				631-447-8300	
EAS	FPATCHOGUE, NY 11772			2d	Business code (see instructions)	
-20	Dian administrator's many and address (if some as also processes	.t "C	"	2h	621111	
LONG	Plan administrator's name and address (if same as plan sponsor, er SISLAND CARDIOLOGY ASSOCIATES, LLP 285 SILLS RO			30	Administrator's EIN 11-3433397	
	EAST PATCH			3c	Administrator's telephone number	
					631-447-8300	
4	If the name and/or EIN of the plan sponsor has changed since the la	ast return/i	report filed for this plan, enter the	4b	EIN	
2	name, EIN, and the plan number from the last return/report.			4c	DN	
	Sponsor's name  Total number of participants at the beginning of the plan year			-		
				- Ou	36	
b	Total number of participants at the end of the plan year			5b	2	
С	Number of participants with account balances as of the end of the p complete this item)		•	5c	4	
6a	Were all of the plan's assets during the plan year invested in eligible				X Yes No	
b	Are you claiming a waiver of the annual examination and report of a		,			
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a				X Yes No	
	If you answered "No" to either 6a or 6b, the plan cannot use Fo	orm 5500-	SF and must instead use Form 5	500.		
Pa	rt III Financial Information					
7	Plan Assets and Liabilities		(a) Beginning of Year		(b) End of Year	
а	Total plan assets	7a	2804605		311078	
b	Total plan liabilities	7b	0		0	
С	Net plan assets (subtract line 7b from line 7a)	7c	2804605		311078	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total	
а	Contributions received or receivable from:		0			
	(1) Employers	8a(1)				
	(2) Participants	8a(2)	0			
	(3) Others (including rollovers)	3) Others (including rollovers)				
b	Other income (loss)	8b	-14684			
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			-14684	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	2478843			
е	Certain deemed and/or corrective distributions (see instructions)	8e	0			
f	Administrative service providers (salaries, fees, commissions)	8f	0			
g g	Other expenses	8g	0			
9 h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			2478843	
;	Net income (loss) (subtract line 8h from line 8c)				-2493527	
' ;	Transfers to (from) the plan (see instructions)		0		2100027	
J	Transiers to (moin) the plan (see instructions)	8j	U			

Form	5500.	SF.	201

Part IV	Plan Characteristics

- If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 9a 2A 2E 2F 2G 2J 3B 3D
  - If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

art	V Compliance Questions						
10	During the plan year:		Yes	No	F	Amount	
а	Was there a failure to transmit to the plan any participant contributions within the time period described 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	d in <b>10a</b>		X			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions report	ed		X			
	on line 10a.)	10b		X			
С	Was the plan covered by a fidelity bond?	10c		^			
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fra or dishonesty?	ud <b>10d</b>		X			
е	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.)	10e		Х			
f	Has the plan failed to provide any benefit when due under the plan?	10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X			
_	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	109					
•	2520.101-3.)	10h		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	10i					
art							
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and	complete	Schoo	lulo SB (	Form		
• •	5500))					Yes	X No
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the C					Yes	X No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)						
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see in	structions	, and e	enter the	date of the	e letter ru	ıling
	granting the waiver.						
lf y	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			
С	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 negative amount)			12d			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?			[	Yes	No	N/A
art							
	Has a resolution to terminate the plan been adopted in any plan year?			X Ye	s No		
Iou			- 1	Λ .0	<u> </u>		
	If "Yes," enter the amount of any plan assets that reverted to the employer this year						
D	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brou of the PBGC?	ght under	the co	ontrol		Yes	X No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident which assets or liabilities were transferred. (See instructions.)	ify the pla	n(s) to				
1	<b>3c(1)</b> Name of plan(s):		13	c(2) EIN	(s)	13c(3	) PN(s)
				` '	. ,	<b>T</b>	. ( )
Caut	ion: A penalty for the late or incomplete filing of this return/report will be assessed unless reaso	nable ca	use is	establis	hed.	-	
	er penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this					ole, a Sch	edule
	r Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this re-			0,		,	

belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	08/30/2012	WILLIAM CLEMANS
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

## Form 5500-SF

Department of the Treasury Internal Revenue Service

## 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 2011

This Form is Open to Public

OMB Nos. 1210-0110

1210-0089

Department of Labor Employee Benefits Security Administration the Internal Revenue Code (the Code). Inspection Pension Benefit Guaranty Corporation ▶ Complete all entries in accordance with the instructions to the Form 5500-SF Annual Report Identification Information 01/01/2011 12/31/2011 For calendar plan year 2011 or fiscal plan year beginning and ending a single-employer plan a multiple-employer plan (not multiemployer) a one-participant plan A This return/report is for: the first return/report the final return/report B This return/report is: an amended return/report a short plan year return/report (less than 12 months) Form 5558 automatic extension DFVC program C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information Three-digit 1a Name of plan plan number LONG ISLAND CARDIOLOGY ASSOCIATES, LLP (PN) 001 401k PROFIT SHARING PLAN Effective date of plan 01/01/1999 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) 11-3433397 LONG ISLAND CARDIOLOGY ASSOCIATES, 2c Sponsor's telephone number (631) 447-8300 285 SILLS ROAD, BUILDING 14 Business code (see instructions) 621111 EAST PATCHOGUE NY 11772 Plan administrator's name and address (if same as plan sponsor, enter "Same") 3b Administrator's EIN SAME **3c** Administrator's telephone number If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN name, EIN, and the plan number from the last return/report. a Sponsor's name 4c PN Total number of participants at the beginning of the plan year ...... 5a b Total number of participants at the end of the plan year..... 5b c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). Yes No 6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) **b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) X Yes No under 29 CFR 2520.104-46? (See Instructions on walver eligibility and conditions.) 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 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year 2,804,605 311,078 a Total plan assets..... 7a **b** Total plan liabilities..... 7b 2,804,605 311,078 C Net plan assets (subtract line 7b from line 7a)...... Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total a Contributions received or receivable from: (1) Employers ...... 8a(1) 8a(2) (2) Participants ..... (3) Others (including rollovers)..... 8a(3) (14,684)**b** Other income (loss)..... 8b (14,684)C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) ...... 8с Benefits paid (including direct rollovers and insurance premiums 2,478,843 to provide benefits)..... 8d Certain deemed and/or corrective distributions (see instructions)... 8e Administrative service providers (salaries, fees, commissions)....... 8f Other expenses..... 8g 2,478,843 h Total expenses (add lines 8d, 8e, 8f, and 8g)..... 8h (2,493,527)Net income (loss) (subtract line 8h from line 8c)..... Transfers to (from) the plan (see instructions) .....

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

		Form 5500-SF 2011 Page <b>2</b> -		_		
Pai	rt	V Plan Characteristics				
9a	۱f	the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Chara 2A 2E 2F 2G 2J 3B 3D	acteris	tic Co	des in t	the instructions:
b	lf	the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Charac	cterist	ic Cod	es in th	ie instructions:
B		( O				
Par				V	N <sub>2</sub>	
10		Ouring the plan year:	r	Yes	No	Amount
а		Vas 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)	10a		х	
b		Vere there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		х	
C		Was the plan covered by a fidelity bond?	10c		Х	
d		oid the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud right-indicated by the plan's fidelity bond, that was caused by fraud	10d		х	
е	i	Vere 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.)	10e		х	
f	ŀ	las the plan failed to provide any benefit when due under the plan?	10f		х	
g	[	old the plan have any participant loans? (if "Yes," enter amount as of year end.)	10g		х	
h		this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 520.101-3.)	10h		х	
į		10h was answered "Yes," check the box if you either provided the required notice or one of the xceptions to providing the notice applied under 29 CFR 2520.101-3	10i			
Part	: V	Pension Funding Compliance				
11		this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 500))				
12	Ī	s this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code f "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)	or se	ction 3	302 of E	ERISA? Yes X No

11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schoop)	edule SB	(Form	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.)				-
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiverMonth			e letter rulin Year	-
lf '	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			
С	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			
е	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?	. X Y	'es No	)	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year		,		0
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the 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) which assets or liabilities were transferred. (See instructions.)	to			
1	3c(1) Name of plan(s):	3c(2) Ell	N(s)	13c(3) P	N(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	James Lantolal	8/28/12	DR. JAMES SEMERTZIDES
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor