Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 	2011
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection
Part I Annual Report Ider	tification 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 multiemployer plan; a multiple-employer plan; or	
	X a single-employer plan; A DFE (specify)	
B This return/report is:	the first return/report; the final return/report;	
	an amended return/report; a short plan year return/report (less t	han 12 months).
C If the plan is a collectively-bargain	ed plan, check here	
D Check box if filing under:	Form 5558; automatic extension;	the DFVC program;
	special extension (enter description)	
Part II Basic Plan Inform	nation—enter all requested information	
1a Name of plan JOSEPH GERARDI, MD, PC PROFI		1b Three-digit plan number (PN) ▶
		1c Effective date of plan 01/01/2002
2a Plan sponsor's name and addres JOSEPH GERARDI, MD, PC	s, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN) 14-1829410
		2c Sponsor's telephone number 518-393-2070
1532 UNION STREET SCHENECTADY, NY 12309	1532 UNION STREET SCHENECTADY, NY 12308	2d Business code (see instructions) 621111

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	Filed with authorized/valid electronic signature.	10/04/2012	JOSEPH GERARDI MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/04/2012	JOSEPH GERARDI MD
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

2-		04	
	Plan administrator's name and address (if same as plan sponsor, enter "Same")		ministrator's EIN -1829410
15	32 UNION STREET CHENECTADY, NY 12309	3c Ad	ministrator's telephone mber 518-393-2070
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
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	5
b	Retired or separated participants receiving benefits	6b	0
c	Other retired or separated participants entitled to future benefits	6c	1
d	Subtotal. Add lines 6a, 6b, and 6c	6d	6
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0
f	Total. Add lines 6d and 6e	6f	6
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	6
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.	6h	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

Form 5500 (2011)

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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2H 2J 3D

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

9a	3a Plan funding arrangement (check all that apply)			9b	Plan ben	efit	arrangement (check all that apply)
	(1)	X	Insurance		(1)		Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)	X	Trust		(3)	Х	Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
а	a Pension_Schedules b General Schedules						
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	X	I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	Х	2 A (Insurance Information)
			actuary		(4)		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

SCHEDULE (Form 5500		Insuranc	e Information	(DMB No. 1210-0110
Department of the Treas Internal Revenue Serv	sury		to be filed under section 104 of t ome Security Act of 1974 (ERIS		2011
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 5500.		
Pension Benefit Guaranty Co	orporation		re required to provide the informa RISA section 103(a)(2).	tion This F	orm is Open to Public Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 01/01/2011	and e	nding 12/31/2011	•
A Name of plan JOSEPH GERARDI, MD,	PC PROFIT SH	HARING/401(K) PLAN		ee-digit n number (PN)	001
C Plan sponsor's name a JOSEPH GERARDI, MD,		e 2a of Form 5500		oyer Identification Numbe	er (EIN)
on a separat		ing Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca NATIONWIDE LIFE INSU					
		I			
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	(f) From	contract year (g) To
31-4156830	66869	0000GERA01NYOOS	6	01/01/2011	12/31/2011
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in item	3 the agents, brokers, an	d other persons in
	amount of comr	nissions paid	(b) 1	otal amount of fees paid	
		0			0
3 Persons receiving com		ees. (Complete as many entries a	· · · · · · · · · · · · · · · · · · ·		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid	
(b) Amount of sales a	nd base	Fee	s and other commissions paid		
commissions pa	id	(c) Amount	(d) Purpos	se	(e) Organization code
	(-) [:	nd address of the agent, broker, o			

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sche	dule A (Form 5500) 2011
			v.012611

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	I	(e) Organization	
	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

P	art II	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier r	nay be treated as	a unit for purposes of
_		this report.	-	
		rrent value of plan's interest under this contract in the general account at year end		0
-		rrent value of plan's interest under this contract in separate accounts at year end	5	86903
6		ntracts With Allocated Funds:		
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO.		
	I -			
	b	Premiums paid to carrier	6b	0
	C	Premiums due but unpaid at the end of the year	6c	0
	d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	6d	0
		Specify nature of costs CONTRACT COMMISSIONS		
	е	Type of contract: (1) X individual policies (2) group deferred annuity		
	C			
		(3) other (specify)		
	-		٦	
	f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here		
7	Con	ntracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		
	b	Balance at the end of the previous year	7b	
	С	Additions: (1) Contributions deposited during the year		
		(2) Dividends and credits		
		(3) Interest credited during the year		
		(4) Transferred from separate account		
		(5) Other (specify below)		
		•		
		(6)Total additions	7c(6)	
	d	Total of balance and additions (add b and c(6))	7d	
	е	Deductions:		
		(1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1)		
		(2) Administration charge made by carrier		
		(3) Transferred to separate account 7e(3)		
		(4) Other (specify below)		
		(5) Total deductions	7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)		

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Pa	rt II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts v					s cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	· ·				
	a	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	v g	Supplemental unem	olovment	h Prescription drug
	. L	Stop loss (large deductible)	i HMO contract	, s_ k∏	PPO contract	bioymon	I Indemnity contract
	'			ĸ	PPO contract		
	m	Other (specify)					
9	F vn e	riance roted contracto.					
9	•	rience-rated contracts: Premiums: (1) Amount received	Г	9a(1)			-
		(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			-
		(3) Increase (decrease) in unearned premium res		9a(3)			1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	-	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			1
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			-
		(C) Other specific acquisition costs	-	9c(1)(C)			-
		(D) Other expenses	E	9c(1)(D)			4
		(E) Taxes		9c(1)(E)			-
		(F) Charges for risks or other contingencies(G) Other retention charges	······	9C(1)(F)			-
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_				
	Ч	Status of policyholder reserves at end of year: (1				\	
	d	(2) Claim reserves				9d(1) 9d(2)	
		(2) Claim reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	-
10		nexperience-rated contracts:		···· •(=)./ ·····		1 00	
		Total premiums or subscription charges paid to c	arrier			10a	
	-	If the carrier, service, or other organization incurr					1
		retention of the contract or policy, other than repo				10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	No	
12 If the	inswer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A		Insuranc	e Information		DMB No. 1210-0110	
(Form 5500))					
Department of the Treat Internal Revenue Serv	sury <i>r</i> ice		to be filed under section 104 of the ome Security Act of 1974 (ERISA		2011	
Department of Labo Employee Benefits Security Ac		File as an at	tachment to Form 5500.			
Pension Benefit Guaranty Co	orporation		re required to provide the informa RISA section 103(a)(2).	tion This F	orm is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plan	year beginning 01/01/2011	and e	nding 12/31/2011		
A Name of plan JOSEPH GERARDI, MD,	, PC PROFIT SI	HARING/401(K) PLAN		ee-digit n number (PN) ▶	001	
-	C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) JOSEPH GERARDI, MD, PC 14-1829410					
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	arrier					
NATIONWIDE LIFE INSU	JRANCE CO.					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
31-4156830	66869	0000GERA00NY00K	2	01/01/2011	12/31/2011	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	l commissions paid. List in item	3 the agents, brokers, an	d other persons in	
(a) Total	amount of comr	nissions paid	(b) T	otal amount of fees paid		
		0			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid		
(b) Amount of sales a			s and other commissions paid			
commissions paid		(c) Amount	(d) Purpos	se	(e) Organization code	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid		

(b) Amount of sales and base	F	Fees and other commissions paid			
commissions paid	(c) Amount	mount (d) Purpose			
For Paperwork Reduction Act Notice	edule A (Form 5500) 2011				

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

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Ρ	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may	he treater	has a unit for nurnoses of
		this report.	be liealed	
4	Curi	ent value of plan's interest under this contract in the general account at year end	4	0
5	Curi	ent value of plan's interest under this contract in separate accounts at year end	5	13819
6		tracts With Allocated Funds:		
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO		
	h		Ch	4070
	b	Premiums paid to carrier Premiums due but unpaid at the end of the year	6b 6c	
	с d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		0
	ŭ	retention of the contract or policy, enter amount	6d	88
		Specify nature of costs CONTRACT COMMISSIONS		
	е	Type of contract: (1) X individual policies (2) group deferred annuity		
		(3) other (specify)		
	f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		
	b	Balance at the end of the previous year	7b	
	С	Additions: (1) Contributions deposited during the year		
		(2) Dividends and credits		
		(3) Interest credited during the year		
		(4) Transferred from separate account		
		(5) Other (specify below)		
			70(6)	
	Ч	(6)Total additions	7c(6) 7d	
		Total of balance and additions (add b and c(6))	70	
	Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1)		
		(2) Administration charge made by carrier		
		(3) Transferred to separate account		
		(4) Other (specify below)		
		▶		
		(5) Total deductions	7e(5)	
	f	Balance at the end of the current vear (subtract e(5) from d)	7f	

Page 4	•
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Pa	rt II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts v					s cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	· ·				
	a	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	v g	Supplemental unem	olovment	h Prescription drug
	. L	Stop loss (large deductible)	i HMO contract	, s_ k∏	PPO contract	bioymon	I Indemnity contract
	'			ĸ	PPO contract		
	m	Other (specify)					
9	F vn e	riance roted contracto.					
9	•	rience-rated contracts: Premiums: (1) Amount received	Г	9a(1)			-
		(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			-
		(3) Increase (decrease) in unearned premium res		9a(3)			1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	-	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			1
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			-
		(C) Other specific acquisition costs	-	9c(1)(C)			-
		(D) Other expenses	E	9c(1)(D)			4
		(E) Taxes		9c(1)(E)			-
		(F) Charges for risks or other contingencies(G) Other retention charges	······	9C(1)(F)			-
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_				
	Ч	Status of policyholder reserves at end of year: (1				\	
	d	(2) Claim reserves				9d(1) 9d(2)	
		(2) Claim reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	-
10		nexperience-rated contracts:		···· •(=)./ ·····		1 00	
		Total premiums or subscription charges paid to c	arrier			10a	
	-	If the carrier, service, or other organization incurr					1
		retention of the contract or policy, other than repo				10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	No	
12 If the	inswer to line 11 is "Yes," specify the information not provided.			

	SCHEDULE I	SCHEDULE I Financial Information—Small Plan						OMB No. 1210-0110		
	(Form 5500)	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the								
	Department of the Treasury Internal Revenue Service						2011			
	Department of Labor Employee Benefits Security Administration			e Code (the Cod	,			Thia	Form in Onen to	Dublia
	Pension Benefit Guaranty Corporation	File as a	an attac	hment to Form	5500.			Inis	Form is Open to Inspection	Public
For	calendar plan year 2011 or fiscal pla	an year beginning 01/01/201	11		а	nd ending	12/3	31/2011		
	Name of plan EPH GERARDI, MD, PC PROFIT SI	HARING/401(K) PLAN				Three-digit plan numb		•	001	
	Plan sponsor's name as shown on li EPH GERARDI, MD, PC	ne 2a of Form 5500				mployer Id 1829410	lentificatio	on Numbe	er (EIN)	
	nplete Schedule I if the plan covered all plan under the 80-120 participant r							lete Scheo	dule I if you are filin	g as a
	rt I Small Plan Financial									
ass ben	port below the current value of asset ets held in more than one trust. Do r refit at a future date. Include all incor urance carriers. Round off amounts	not enter the value of the portion ne and expenses of the plan inc	of an ir	surance contrac	t that g	uarantees	during th	is plan ye	ear to pay a specifie	c dollar
1	Plan Assets and Liabilities:			(a) Be	ginning	g of Year			(b) End of Year	
а	Total plan assets		. 1a			4	15267			441281
b	Total plan liabilities		. 1b		0			0		
С	Net plan assets (subtract line 1b fr	om line 1a)	1c		415267			441281		
2	Income, Expenses, and Transfer	s for this Plan Year:		(a) Amo	ount			(b) Total	
а	Contributions received or receivable	e:								
	(1) Employers		. 2a(1)				30000			
	(2) Participants		2a(2)				8710			
					0					
b		cash contributions				0				
с	Other income		2c				-8152			
d	Total income (add lines 2a(1), 2a(2				30					30558
e	Benefits paid (including direct rollo						0			
f	Corrective distributions (see instrue						0			
g	Certain deemed distributions of pa	,					-			
5	(see instructions)	•	. 2g				0			
h	Administrative service providers (s	alaries, fees, and commissions)	. 2h				4544			
i	Other expenses		. 2i		0					
j	Total expenses (add lines 2e, 2f, 2	g, 2h, and 2i)	. 2j							4544
k	Net income (loss) (subtract line 2j f	rom line 2d)	. 2k							26014
Ι	Transfers to (from) the plan (see in	structions)	. 21							0
3	Specific Assets: If the plan held as remaining in the plan as of the end of by-line basis unless the trust meets of	the plan year. Allocate the value of	of the pla	n's interest in a co						
				г		Yes	No		Amount	
а	Partnership/joint venture interests.				3a		X			
b	Employer real property				3b		X			
С	Real estate (other than employer re	eal property)			3c		X			
d	Employer securities				3d		X			
е	Participant loans				3e		X			
For	Paperwork Reduction Act Notice	and OMB Control Numbers, s	ee the i	nstructions for	Form	5500			Schedule I (Form	5500) 2011

hedule	l (Form	5500)	201	1
		v.01	261	1

			Yes	No	Amount
3f	Loans (other than to participants)	3f		Х	
g	Tangible personal property	3g		X	

Pa	art II	Compliance Questions				
4	During	the plan year:		Yes	No	Amount
а	describe	re a failure to transmit to the plan any participant contributions within the time period d in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully d. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		x	
b	year or o	y loans by the plan or fixed income obligations due the plan in default as of the close of plan classified during the year as uncollectible? Disregard participant loans secured by the int's account balance	4b		X	
С		y leases to which the plan was a party in default or classified during the year as tible?	4c		Х	
d		ere any nonexempt transactions with any party-in-interest? (Do not include transactions on line 4a.)	4d		X	
е	Was the	plan covered by a fidelity bond?	4e	Х		40000
f		plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by dishonesty?	4f		X	
g		blan hold any assets whose current value was neither readily determinable on an established nor set by an independent third party appraiser?	4g		X	
h		plan receive any noncash contributions whose value was neither readily determinable on an ned market nor set by an independent third party appraiser?	4h		X	
i		blan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel state, or partnership/joint venture interest?	4i		X	
j		the plan assets either distributed to participants or beneficiaries, transferred to another plan, ht under the control of the PBGC?	4j		X	
k	accounta	claiming a waiver of the annual examination and report of an independent qualified public ant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 nt. (See instructions on waiver eligibility and conditions.)	4k	X		
I	Has the	plan failed to provide any benefit when due under the plan?	41		Х	
m		an individual account plan, was there a blackout period? (See instructions and 29 CFR 1-3.)	4m		X	
n		is answered "Yes," check the "Yes" box if you either provided the required notice or one of providing the notice applied under 29 CFR 2520.101-3	4n			
5a		solution to terminate the plan been adopted during the plan year or any prior plan year? ' enter the amount of any plan assets that reverted to the employer this year	Ye	s 🗙 N	0 A	mount:

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)

5b(2) EIN(s)

5b(3) PN(s)

5500 Electronic Filing Authorization

 Plan Name:
 JOSEPH GERARDI, MD, PC PROFIT SHARING/401(K) PLAN

 EIN/PN:
 14-1829410/001

 Plan Year:
 01/01/2011 - 12/31/2011

I hereby authorize Anthony S. Asterino, CPA to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator n Derardi aes

(sign)

 $\frac{10-4-12}{(date)}$

í

Plan Sponsor seph Derand -4-12

date)

Form 5500	Annual Return/Report of Employe	ee Benefit Plan	OMB N	os. 1210-0110 1210-0089
Department of the Treasury				
Internal Revenue Service	2011			
Employee Benefits Security Administration	 Complete all entries in accordance the Instructions to the Form 55 			
Pension Benefit Guaranty Corporation			This Form Is Open to Inspection	o Public
	Identification Information			
For the calendar plan year 20	11 or fiscal plan year beginning 01/01/2011	and ending 12/3	· ·	
A This return/report is for:	a multiemployer plan:	a multiple-employer	plan; or	
	X a single-employer plan;	a DFE (specify)		
B This return/report is:	the first return/report:	the final return/repor	t:	
	an amended return/report;		urn/report (less than 12 m	nonths).
C If the plan is a collectively-ba	rgained plan, check here	•••••		
D Check box if filing under:	X Form 5558;	automatic extension	; the DFVC p	rogram;
	special extension (enter description)			
Part II Basic Plan Inf	ormation enter all requested information.			
1a Name of plan			1b Three-digit plan	
JOSEPH GERARDI, M), PC PROFIT SHARING/401(K) PLAN		number (PN) 🕨	001
			1C Effective date of pla 01/01/2002	an
	address, including room or suite number (Employer, if for sin	ale employer plan)	2b Employer Identifica	tion
2a Plan sponsor's name and	address, including room of suite number (Employer, in of sin	gie-employer plant	Number (EIN)	
			14-1829410	
JOSEPH GERARDI, M), PC		2c Sponsor's telephor	e
			number	
			(518) 393-207	70
1532 UNION STREET			2d Business code (see instructions)	9
	NY 12309		621111	
US SCHENECTADY	NI 12303			

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	Joseph Derarchi	10-4-12	Joseph Gerardi, MD
2	Signature qi plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Joseph Herardi	10-4-12	Joseph Gerardi, MD
	Signature overployer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2011) v.012611

	Form 5500 (2011) Page 2		
 3a	Plan administrator's name and address (if same as plan sponsor, enter "Same")	3b /	Administrator's EIN
	Sane		Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:		4b EIN
a	Sponsor's name		4C PN
5	Total number of participants at the beginning of the plan year	5	6
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		Terretaria de la companya de la comp
a	Active participants	6a	5
b	Retired or separated participants receiving benefits	6b	0
C	Other retired or separated participants entitled to future benefits	6c	1
d	Subtotal. Add lines 6a, 6b, and 6c	. 6d	6
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. <u>6</u> e	0
f	Total. Add lines 6d and 6e	. 6f	6
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. <u>6g</u>	6
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	. 6h	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer complete this item)	. 7	
8a	I If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Co	des in i	ne instructions:
	2E 2H 2J 3D		
1	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Cod	es in th	e instructions:

9a	Plan funding arrangement (check all that apply)	9b	Plan	be	nefit arrangement (check all that apply)
	(1) X Insurance		(1)	L	Insurance
	(2) Code section 412(e)(3) insurance contracts		(2)	L	Code section 412(e)(3) insurance contracts
	(3) X Trust		(3)	X	Trust
	(4) General assets of the sponsor		(4)		General assets of the sponsor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attact	ned, and	l, wher	re i	ndicated, enter the number attached. (See instructions)
а	Pension Schedules	b	Gen	era	l Schedules
	(1) R (Retirement Plan Information)		(1)		H (Financial Information)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	X	1 (Financial Information - Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan		(3)	x	2 A (Insurance Information)
	actuary		(4)	Π	C (Service Provider Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(5)	Γ	D (DFE/Participating Plan Information)
	Information) - signed by the plan actuary		(6)	Γ	G (Financial Transaction Schedules)

Sponsor Location Information

Sponsor name: JOSEPH GERARDI, MD, PC Sponsor DBA name: Sponsor care of name:

1532 Union Street

US Schenectady NY 12308

SCHEDU		Insurance Information					3 No. 1210-0110
Department of the Internal Revenue	Treasury	This schedule is requir Employee Retirement Inco			f the		2011
Department of Employee Benefits Secur		 File as an attac 	chment to Form 5	500.	:		
Pension Benefit Guarat		Insurance companies are pursuant to EF	required to provide th RISA section 103(a)(2			This Fo	orm is Open to Public Inspection.
For calendar plan ye	ar 2011 or fiscal pla	an year beginning 01/01/20	11	and ending	12/31	/2011	
A Name of plan				B Three-dig plan num		►	001
JOSEPH GERARDI,	MD, PC PROFI	IT SHARING/401(K) PLAN					
C Plan sponsor's	name as shown on	line 2a of Form 5500.		D Employer Indentification Number (EIN)			
JOSEPH GERARDI	MD. PC				14-182	9410	
Dorf I Inform	ation Concerni	ng Insurance Contract Con Individual contracts grouped as a u	verage, Fees, an unit in Parts II and III	d Commiss can be reporte	ions Provi ed on a singl	ide information e Schedule A.	n for each contract
1 Coverage Inform	mation:						
(a) Name of insuran	ce carrier						
NATIONWIDE LIFT	INSURANCE CO	ο.					
		}	(e) Approximate			Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covere _policy or cont		(f) F	rom	(g) To
31-4156830	66869	0000gera01NyOOS		6	1/1/20		12/31/2011
2 Insurance fee a	ind commission info	ormation. Enter the total fees and t	otal commissions pai	d. List in item	3 the agents	, brokers, and	l other persons in
	er of the amount pa			(b) Tota	I amount of	fees paid	
(a) Total amount of c					0	
3 Persons receiv		nd fees. (Complete as many entries					
		and address of the agent, broker, o				in an anala	

	Fees a		
(b) Amount of sales and base commissions paid	(C) Amount	(d) Purpose	(e) Organization code
		an a	
(a) Name a	nd address of the agent, broker, or o	other person to whom commissions or fees were	e paid

	Fees a			
(b) Amount of sales and base commissions paid	(C) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	and OMB Control Numbers, see th	ne Instructions for Form 5500.	Schedule A (Form 5500) 2011 v.012611	

Page 2-

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees a		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Name	and address of the agent, broker or	other person to whom commissions or fees we	ere paid

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 (e) Organization code

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of option and hang	f base Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
	1			
and the second			••	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

	Fees a		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		-it	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(h) Amount of onlos and base	Fees a		
(b) Amount of sales and base commissions paid	(c) Amount	(c) Amount (d) Purpose	

Pa	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual	ridual contr	acts with e	each carrier m	ay be treated	l as a unit for purposes of
	this report.				4	0
	Current value of plan's interest under this contract in the general account at year		• • •	• • • • •	4 5	86,903
6	Current value of plan's interest under this contract in separate accounts at year e Contracts With Allocated Funds: State the basis of premium rates NOT PROVIDED BY INSURANCE CO.		<u></u>	• • • • •	<u>. </u>	
	O Premiums paid to carrier				6b	0
(Premiums due but unpaid at the end of the year	• • •	• • •		6c	0
1	If the carrier, service, or other organization incurred any specific costs in con or retention of the contract or policy, enter amount	nection wit	h the acqu	isition • • • • • •	6d	0
	Specify nature of costs					
	CONTRACT COMMISSIONS Type of contract (1) x individual policies (2) group deferred an (3) other (specify) ►				-	
1	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here)	▶□	
7	Contracts With Unallocated Funds (Do not include portions of these contracts m					
а	Type on contract (1) 🗌 deposit administration (2) 📙 in	nmediate	participatio	n guarantee		
	(3) guaranteed investment (4)	ther 🕨				
	Balance at the end of the previous year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	· · · · · ·	· · · · · ·	7b	
					<u>, i i i i</u>	
	(6) Total additions				7c(6)	
C e		• • •	•••		<u>7d</u>	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
	(2) Administration charge made by carrier	7e(2)		<u>-</u>		
	(3) Transferred to separate account	7e(3)	<u> </u>			
	(4) Other (specify below)	<u>7e(4)</u>				
		L			7e(5)	the second s
ſ	(5) Total deductions	 . <u></u> .	••••	 <u>.,</u>	7f	

Schedule A (Form 5500) 201
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Specify nature of costs ►

Pao	е	4	
r au	С.	-	

Par	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employ information may be combined for reporting purposes if such contracts are experience the entire group of such individual contracts with each carrier may be treated as a u	ce-rated as a unit. Where contracts of	oyee organization(s), the cover individual employees,
8	Benefit and contract type (check all applicable boxes) a b Dental c a Health (other than dental or vision) b Dental c e Temporary disability (accident and sickness) f Long-term disability g i Stop loss (large deductible) j HMO contract k m Other (specify) ►		d 🗌 Life insurance h 🗍 Prescription drug I 📄 Indemnity contract
9 a	(2) Increase (decrease) in amount due but unpaid	9a(1) 9a(2) 9a(3)	
b	(4) Earned ((1) + (2) - (3))		
С	(C) Other specific acquisition costs	:(1)(A) :(1)(B) :(1)(C)	
	(D) Other expenses 90 (E) Taxes 90 (F) Charges for risks or other contingencies 90 (G) Other retention charges 90 (H) Total retention 90	(1)(D) (1)(E) (1)(F) (1)(G)	
d e	 (2) Dividends or retroactive rate refunds. (The amounts were paid in cash, or Status of policyholder reserves at end of year: (1) Amount held to provide benefits after r (2) Claim reserves	credited.) . 9c(2) retirement . 9d(1) 	
	Nonexperience-rated contracts: Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with t retention of the contract or policy, other than reported in Part 1, item 2 above, report amou	the acquisition or unt	

Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to complete Schedule A?		Г	Yes	No	
12 If the answer to line 11 is "Yes," specify the information not provided.					

SCHEDULE A (Form 5500)	Insura	Insurance Information This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				No. 1210-0110
Department of the Treasury Internal Revenue Service	· · · · · · · · · · · · · · ·					
Department of Labor Employee Benefits Security Administration	► File as an att	achment to Form 5	500.			
Pension Benefit Guaranty Corporation	 Insurance companies an pursuant to l 	e required to provide th ERISA section 103(a)(2			This Fo	rm is Open to Public Inspection.
For calendar plan year 2011 or fis	cal plan year beginning 01/01/2	011	and ending	12/31	/2011	
A Name of plan			B Three-dig plan num		Þ	001
JOSEPH GERARDI, MD, PC I	ROFIT SHARING/401(K) PLAN	ſ				
C Plan sponsor's name as show	n on line 2a of Form 5500.		D Employe	r Indentificatio	on Number (El	N)
JOSEPH GERARDI, MD, PC				14-1829	9410	
Part I Information Con- on a separate Schedu 1 Coverage Information:	erning Insurance Contract Co le A. Individual contracts grouped as a	overage, Fees, an a unit in Parts II and III	d Commiss can be report	sions Provid ed on a single	le information Schedule A.	for each contract
(a) Name of insurance carrier						
NATIONWIDE LIFE INSURAN	E CO.					
(c) N/	· · · · · · · · · · · · · · · · · · ·	(e) Approximate			Policy or	contract year
(b) EIN code	IC (d) Contract or identification number	persons covere policy or cont		(f) Fro	om	(g) To
31-4156830 6686	9 0000GERA00NY00K			1/1/20:	11	12/31/2011
2 Insurance fee and commission descending order of the amo	n information. Enter the total fees and	I total commissions pai	d. List in item	3 the agents,	brokers, and	other persons in
	t of commissions paid		(b) Tota	I amount of fe	ees paid	
	0				0	
	ns and fees. (Complete as many entri			<u></u>		<u></u>
(a) N	ame and address of the agent, broker	, or other person to wh	om commissi	ons or fees we	ere paid	

	Fees a		
(b) Amount of sales and base commissions paid	(C) Amount	(d) Purpose	(e) Organization code
(a) Name a	and address of the agent, broker, or	other person to whom commissions or fees were p	aid

(b) Amount of polon and base	Fees a	nd other commissions paid	
(b) Amount of sales and base commissions paid	(C) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	and OMB Control Numbers, see th	he Instructions for Form 5500.	Schedule A (Form 5500) 2011 v.012611

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			Alexander - Sala Maria de Carlo de Carlo Compositivo de Carlo d
(a) Nam	e and address of the agent, brok	ker or other person to whom commissions or fees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 (e) Organization code

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base	F	ees and other commissions paid	4
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	1		

Page 2-

Da	Investment and Annuity Contract Information				
	Where individual contracts are provided, the entire group of such individual this report.	idual contracts with e	each carrier may	be treated	as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at year	end		4	0
5	Current value of plan's interest under this contract in separate accounts at year e			5	13,819
6	Contracts With Allocated Funds: a State the basis of premium rates ► NOT PROVIDED BY INSURANCE CO		-		
1	b Premiums paid to carrier	• • • • • •		6b	1,870
	C Premiums due but unpaid at the end of the year	• • • • • •		<u>6c</u>	0
I	d If the carrier, service, or other organization incurred any specific costs in con or retention of the contract or policy, enter amount	nection with the acqu	isition	6d	
	Specify nature of costs				
	CONTRACT COMMISSIONS ■ Type of contract (1) x individual policies (2) group deferred and (3) other (specify) ►			▶□	
	f If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan check here		▶	
7	Contracts With Unallocated Funds (Do not include portions of these contracts m				
а		nmediate participatio	n guarantee		
	(3) guaranteed investment (4) guaranteed investment	ther 🕨			
	Balance at the end of the previous year	7c(1) 7c(2) 7c(3)	[7b	
		7c(4)			
	(4) Transferred from separate account	7c(5)			
	(5) Other (specify below)				
		ter and the second s		7c(6)	
_	(6) Total additions			7d	
0	Total of balance and additions (add b and c(6)) · · · · · · · · · · · · · · · · · ·				
	 Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year 	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
					n in 2000 - CEN, National State (Salations)
	-		· · · · ·		
		· ·			
				7e(5)	We are a set of the control of the set of th
	(5) Total deductions	•••••	· · · · }	7e(5) 7f	
	Balance at the end of the current year (subtract e(5) from d).	• • • <u>•</u> • • •	<u> </u>		· · · · · · · · · · · · · · · · · · ·

Page	4	
Page	4	

Par	Welfare Benefit Contract Information		·
	If more than one contract covers the same group of employees of the same er information may be combined for reporting purposes if such contracts are expet the entire group of such individual contracts with each carrier may be treated a	erience-rated as a unit. Where contracts (oyee organization(s), the cover individual employees,
8	Benefit and contract type (check all applicable boxes)		
	a Health (other than dental or vision) b Dental	C 🗌 Vision	d 🗌 Life insurance
	e Temporary disability (accident and sickness) f D Long-term disability	g 🗌 Supplemental unemployment	h Prescription drug
	i Stop loss (large deductible) j HMO contract	k PPO contract	I Indemnity contract
			,
	m Other (specify) ►		• · · · · · · · · · · · · · · · · · · ·
9	Experience-rated contracts:		
а	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	4
	(3) Increase (decrease) in unearned premium reserve	<u>9a(3)</u>	<u>na in antistica in an</u>
	(4) Eamed ((1) + (2) - (3))		
b	Benefit charges: (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		
	(4) Claims charged	· · · · · · · · · · · [30(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis)	9c(1)(A)	
	(A) Commissions	9c(1)(B)	
	(B) Administrative service or other fees	9c(1)(C)	
	(C) Other specific acquisition costs	9c(1)(D)	
	(D) Other expenses	9c(1)(E)	
	(E) Taxes	9c(1)(F)	
	(F) Charges for risks or other contingencies	9c(1)(G)	
	(H) Total retention $\cdot \cdot \cdot$		
	(2) Dividends or retroactive rate refunds. (The amounts were paid in cash,		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits a		
u	(2) Claim reserves		
	(2) Other reserves		
е	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	9e	
10	Nonexperience-rated contracts:		And the second sec
a	Total premiums or subscription charges paid to carrier		
b	If the carrier, service, or other organization incurred any specific costs in connection	with the acquisition or	
	retention of the contract or policy, other than reported in Part I, item 2 above, report a	amount 10b	

Specify nature of costs 🕨

Part IV Provision of Information				 	
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	 <u>.</u>	.	Yes	No	
12 If the answer to line 11 is "Yes," specify the information not provided.					

	SCHEDULE I	Financial Informat	tion Sr	Small Plan OMB No. 1210-0110				
	(Form 5500)	This schedule is required to be filed						
	Department of the Treasury Internal Revenue Service	Retirement Income Security Act of 197 Internal Revenue (2011					
Ел	Department of Labor ployee Benefits Security Administration	► File as an attachme	This Form is Open to Public Inspection.					
	Pension Benefit Guaranty Corporation		<u> </u>					
For	calendar plan year 2011 or fiscal plan	year beginning 01/01/2011		and ending		<u>1</u>		
	Name of plan				B Three-digit			
	JOSEPH GERARDI, MD, PC PR	OFIT SHARING/401(K) PLAN			plan number	(PN) ► 001		
C	Plan sponsor's name as shown on line	e 2a of Form 5500			D Employer Id	entification Number (EIN)		
	JOSEPH GERARDI, MD, PC				14-18294	10		
Compl	ete Schedule I if the plan covered few	ver than 100 participants as of the beginning (see instructions). Complete Schedule H if	g of the plar reporting as	n year. You m s a large plan	ay also complete or DFE.	Schedule I if you are filing as a		
_	rt I Small Plan Financial							
assets benefi	hald in more than one trust. Do not e	d liabilities, income, expenses, transfers an enter the value of the portion of an insurance and expenses of the plan including any trus the nearest dollar.	e contract tr	nat quarantee	is during this plan	year to pay a specific uolial		
1	Plan Assets and Liabilities:			(a) Beginni	ing of Year	(b) End of Year		
a	Total plan assets		1a		415,26	441,28		
b	Total plan liabilities		1b					
c	Net plan assets (subtract line 1b fror	n line 1a)	1c		415,26	441,28		
2	Income, Expenses, and Transfe			(a) Amo	punt	(b) Total		
a	Contributions received or receivable		· ·					
a	(1) Employers		2a(1)		30,00			
	(2) Participants		2a(2)	1	8,71			
	(3) Others (including rollovers)		2a(3)	1		5		
h	Noncash contributions		2b					
	Other income		2c		(8,152)			
~						We want a manage with the second second		
С А	- ···-·	2a(3) 2h and 2c)	2d			30,55		
c d	Total income (add lines 2a(1), 2a(2)							
c d e	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow	ers)	2d	······································		30,55		
e f	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct	ers)	2d 2e			<u>30,55</u>		
	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part	ers)	2d 2e 2f			<u>30,55</u>		
e f g	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e			30,55 0 0		
e f	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions) Administrative service providers (sa	ers)	2d 2e 2f 2g 2h		4,54	30,55 0 0		
e f g	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i		4,54	30,55 0 0 4		
e f g	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions) Administrative service providers (sa Other expenses Total expenses (add lines 2e, 2f, 2g	ers)	2d 2e 2f 2g 2h		4,54	30,55 0 0 4 0		
e f g	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions) Administrative service providers (sa Other expenses Total expenses (add lines 2e, 2f, 2g Net income (loss) (subtract line 2j fm	ers)	2d 2e 2f 2g 2h 2i 2j 2k		4,54	30,55 0 0 4 0 4 0 4,54		
e f g h i j k	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions) Administrative service providers (sa Other expenses Total expenses (add lines 2e, 2f, 2g Net income (loss) (subtract line 2j fr Transfers to (from) the plan (see ins	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l	gories, check *	4,54	30,55 0 4 0 4 0 4,54 26,01 current value of any assets		
e f g	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l collowing cate est in a comm	gories, check " ningled trust cc	4,54	30,55 0 4 0 4 0 4,54 26,01 current value of any assets		
e f g h i j k	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l collowing cate est in a comm	gories, check " ningled trust cc	4,54	30,55 0 4 0 4 0 4,54 26,01 current value of any assets		
e f g h i j k 	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l cllowing cate est in a communications.	ningled liusi a	4,54 Yes" and enter the ontaining the assets Yes No	30,55 30 4 30 4 5 5 5 5 5 5 5 5 5 5 5 5 5		
e f g h j k J 3 a	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l cllowing cate est in a communications.	3	4,54 'Yes" and enter the ontaining the assets Yes No A X	30,55 30,55 30 4 50 4 4,54 26,01 current value of any assets of more than one plan on a line-		
e f g h j k J 3 a b	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l collowing cate est in a communications.	3	4,54 Yes" and enter the ontaining the assets Yes No a x b x	30,55 30,55 30 4 50 4 4,54 26,01 current value of any assets of more than one plan on a line-		
ef g h j k 	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions) Administrative service providers (sa Other expenses Total expenses (add lines 2e, 2f, 2g Net income (loss) (subtract line 2j fr Transfers to (from) the plan (see ins Specific Assets: If the plan held asse remaining in the plan as of the end of th by-line basis unless the trust meets one Partnership/joint venture interests Employer real property Real estate (other than employer re	ars)	2d 2e 2f 2g 2h 2i 2j 2k 2l cllowing cate est in a communications.	3	4,54 Yes" and enter the ontaining the assets Yes No a X b X C X	30,55 30,55 30 4 50 4 4,54 26,01 current value of any assets of more than one plan on a line-		
e f g h j k J 3 a b	Total income (add lines 2a(1), 2a(2) Benefits paid (including direct rollow Corrective distributions (see instruct Certain deemed distributions of part (see instructions)	ers)	2d 2e 2f 2g 2h 2i 2j 2k 2l ottowing cate est in a communications.	3 3 3	4,54 Yes" and enter the ontaining the assets Yes No a X b X	30,55 30,55 30 4 50 4 4,54 26,01 current value of any assets of more than one plan on a line-		

Page 2-	
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		Ye	8	No	Amount
3f	Loans (other than to participants)	F		x	
g	Tangible personal property	g		x	
Partl		Ye			A
4	During the plan year:	Te	8	No	Amount
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program)	8	•	X	<u> </u>
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	b	·· 1	x	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	C		x	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	d		x	
е	Was the plan covered by a fidelity bond?	e >	(40,000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			x	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	g		x	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		•••••	x	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	i	·i	x	<u> kod 4 4</u>
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	j	: 	x	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No", attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	k J	ĸ		
1	Has the plan failed to provide any benefit when due under the plan?			x	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	<u>m</u>		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of	n		· · · · · · · · · ·	
	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?				
	if "Yes," enter the amount of any plan assets that reverted to the employer this year Yes	X	lo	Amount	•
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) transferred (See instructions.)	s) to wh	iich a	ssets or lia	bilities were

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

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Par	t I Identification						· · · · · · · · · · · · · · · · · · ·		
A	Name of filer, plan administrator, or plan sponsor (see instructions)	B Filer's identifying number (see Instructions) Employer identification number (EIN)							
~	JOSEPH GERARDI, MD, PC								
	Number, street, and room or suite no. (If a P.O. box, see instructions)		14-	182941	0				
	1532 UNION STREET			cial secur	ity number (SSI	N) (see instru	ictions)		
	City or town, state, and ZIP code SCHENECTADY NY 12309								
C	Plan name			an		an year er			
			nun	nber	MM		YYYY		
	1 JOSEPH GERARDI, MD, FC PROFIT SHARING/401(K) PLAN	0	 0	1	12	31	2011		
			1	1	ļ				
	2		l	<u> </u>	-				
			I	I					
	3								
Pa	t II Extension of Time To File Form 5500 Series, and/or Form 8955	-SSA							
1	I request an extension of time until 10 / 15 / 2012 to file Form	5500 :	serie	s (see in	structions).				
•	Note. A signature IS NOT required if you are requesting an extension to file Form 5500			•	÷				
	Hore, A signature to hor requires in you are requeering an extension to me y enh ever								
2	I request an extension of time until to file Form 8955-SSA (see instructions).								
-	Note. A signature IS required if you are requesting an extension to file Form 8955-SSA.								
	The application is automatically approved to the date shown on line 1 and/or line 2 (the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extend and/or line 2 (above) is not later than the 15th day of the third month after the normal	sion is :	requ	a) the For ested, an	rm 5558 is file nd (b) the date	d on or bef e on line 1	ore		
Par	t III Extension of Time To File Form 5330 (see instructions)								
3	I request an extension of time untilto file Form You may be approved for up to a 6 month extension to file Form 5330, after the norma		late (of Form (5330.				
а	Enter the Code section(s) imposing the tax	►	Ŀ	a					
-									
b	Enter the payment amount attached	• •	•	• • •	· · •	b			
с 4	For excise taxes under section 4980 or 4980F of the Code, enter the revision/amendm State In detail why you need the extension:	nent da	te	••		C			
-									
				_					
							·····		

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.