			eturn/l Benefit	Report of Small Employ	mall Employee OMB Nos. 1			
	Department of the Treasury Internal Revenue Service	_		ctions 104 and 4065 of the Employed	0	2	2011	
En	Department of Labor nployee Benefits Security Administration	Retirement Income Security Act of	1974 (ER	ISA), and sections 6057(b) and 6058 Code (the Code).	This Form is Open to Public			
P	ension Benefit Guaranty Corporation	Complete all entries in accord	dance witl	h the instructions to the Form 5500	0-SF.	Ins	pection	
-		entification Information						
For	calendar plan year 2011 or fisca				2/31/2	2011		
Α 1	This return/report is for:	a single-employer plan	•	e-employer plan (not multiemployer)		a one-partici	pant plan	
B -	This return/report is:	the first return/report		eturn/report				
		an amended return/report	a short pla	an year return/report (less than 12 mo	onths))		
C	Check box if filing under:	Form 5558	automatic	extension		DFVC progra	ım	
		special extension (enter description						
		nation—enter all requested information	ation					
	Name of plan				1b	Three-digit plan number		
TAK I	SDALE MEDICAL GROUP PC					(PN)	002	
					1c	Effective date o	f plan	
						01/01		
2a HAR	Plan sponsor's name and addre	ess; include room or suite number (e	mployer, if	for a single-employer plan)	2b	Employer Identi (EIN) 13-28	fication Number 43597	
180 E	HARTSDALE AVE	180 E HART		/F	2c	Sponsor's telep 914-72		
STE ²		STE 1 E HARTSDALE			2d	Business code (6211	,	
	Plan administrator's name and SDALE MEDICAL GROUP PC	address (if same as plan sponsor, er 180 E HARTS			3b	Administrator's 13-28	EIN 43597	
		STE 1 E HARTSDALE	, NY 1053	0	3c	Administrator's 914-72	elephone number 5-2010	
4		lan sponsor has changed since the l	ast return/	report filed for this plan, enter the	4b	EIN		
а	name, EIN, and the plan numb Sponsor's name	er from the last return/report.			4c	PN		
	•	the beginning of the plan year			5a		12	
b	Total number of participants at	the end of the plan year			5b		0	
		count balances as of the end of the p			00			
	1 /				5c		6	
				(See instructions.)			X Yes No	
b				ident qualified public accountant (IQI			X Yes No	
_			orm 5500-	SF and must instead use Form 550	00.			
	rt III Financial Informa	ation						
7	Plan Assets and Liabilities			(a) Beginning of Year 262415		(b) End	of Year 121712	
a b	•			202413			121712	
b C	•	b from line 7a)	7b 7c	262415			121712	
8	Income, Expenses, and Transf			(a) Amount		(b)]	otal	
a	Contributions received or recei					(6)	otai	
	(1) Employers		. 8a(1)		_			
	(2) Participants							
_	(3) Others (including rollovers)		8a(3)		_			
	()			-10238	_		10000	
		8a(2), 8a(3), and 8b)	. 8c		_		-10238	
d		ollovers and insurance premiums	. 8d	130465				
е	Certain deemed and/or correct	ive distributions (see instructions)	. 8e					
f	Administrative service provider	s (salaries, fees, commissions)	8f					
g	Other expenses		. 8g					
h	Total expenses (add lines 8d, 8	Be, 8f, and 8g)	8h				130465	
i		e 8h from line 8c)	8i				-140703	
j	Transfers to (from) the plan (se	e instructions)	8j					

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

Page 2 - 1

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:

2E 2G 2J 2K 2T 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	A	mount	
а	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)	10a		Х			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		Х			
С	Was the plan covered by a fidelity bond?	10c	Х			;	36579
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		Х			
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		x			
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		Х			
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		Х			
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		Х			
Part	VI Pension Funding Compliance						
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 5500))	plete	Sched	ule SB	(Form	Yes	X No
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code					Yes	X No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)						
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruct granting the waiver						ng
lf y	ou 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 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?			XY	es No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	1	3a				0
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought of the PBGC?					Yes	X No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the which assets or liabilities were transferred. (See instructions.)	ne pla	n(s) to				
1	3c(1) Name of plan(s):		13	:(2) Ell	N(s)	13c(3) F	PN(s)
Caut	on: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonab	le cau	ise is	establi	shed.	<u>.</u>	
	penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this retu					le, a Scheo	dule

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	Filed with authorized/valid electronic signature.	10/15/2012	MAXWELL CHAIT
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

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Form 5500-SF Department of the Treasury Internal Rovenue Service	Short Form Annual Re Bi	anafit Plan		OMB Nos, 1210-01 1210-00		
Department of Lebor Employee Benefits Seounty Administration	This form is required to be filed un Retirement income Security Act of 1 of the internal	974 (ERISA), and eections	5 of the Employee 6057(b) and 6058(a)	2011		
Pension Benefit Querinty Corporation	🗩 Complete ell'entries in accordan	revenue Codo (the Code), ice with the instructions i	the Form 5500-SE			
	rt Identification Information			to Pablib Inspec		
For calendar plan year 2011 or fl A This return/report is for:		1/2011	and ending 1	2/31/2011		
B This return/report is lor.	X a single-employer plan the first return/report	a multiple-employer plan (r	hot multiomployer)	a one-participant pla		
	· · · · · · · · · · · · · · · · · · ·	the final return/report a short plan year return/rej	Dott /lean than 10 marks	L-1		
C Check box if filing under:		automatic extension		ne) DFVC program		
Part II Basic Plan Int	spoalal extension (enter descript	tion)				
18 Name of plan	formation - onter all requested infor	mation				
HARTSDALE MEDICAL	GROUP PC		1b Three-digit plan number (P			
			10 Effective date of	P I VV		
				1,1998		
2a Plan sponsor's name and addres	ss; include room or suite number (employer	, if (or single-employer plan)		ification Number (EIN		
HARTSDALE MEDICAL	GROUP PC	, - , ,	13-28	343597		
180 E HARTSDALE A			2c Sponsor's telep	hone number		
STE 1 E			914-725-201			
LARTSDALE	NY 10530		2d Business code			
a Plan administrator's name an	id address (if same as plan sponsor, er	ter "Same")	62111 3b Administrator's			
SAME			Administrators			
			3c Administrator's	telephone number		
' IT THU DEMO SOCIAL LINE OF THE O						
	ian aponsor has changed since the last	t roturn/report filed for this	4b EIN			
plan, enter the name, EIN, and	lan sponsor has changed since the last the plan number from the last return/re	t roturn/report filed for this port.	·			
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Page 2-

Form 5500-SF (2011)

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: 2E 2G 2J 2K 2T 3D

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

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	in 29 GFR	2510.3-1027 (See ine	tructions and DO	L'à Voluntary Fiduciary	Correction Program.)	10a		x		
p	Were the	ro any nonexempt tr	ansactions with a	nv partv-in-interest? (Dr	not include	<u>iva</u>	•			
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C	Was the p	plan covered by a fic	ielity bond?	************	4434774273474474747474747474747474747474	10c	x	- <u>-</u>		26 50
d	Did the pi	ian have a loss, whe	ther or not reimbu	irsed by the plan's fidel	hibbod that	100	<u> </u>			36,57
	was caus	ed by fraud or disho	nestv?			10d	Í	X		
θ	Were any	fees or commission	a paid to any broi	ers, agents, or other pe	arsone by on Insurance	iva	•••••	<u>~</u> ~		
	carrier, In:	surance service or o	ther organization	that provides some or a	I of the bonefits under			1		
	the plan?	(See instructions.)				100		x		
f	Has the p	lan failed to provide	any benefit when	due under the plan?	***************************************	100		Ŷ		n
 f Has the plan failed to provide any benefit when due under the plan? g Did the plan have any participant loans? (If "Yes," enter amount as of year end.) 								Ŷ		
h:	If this is a	n Individual account	olan, was there a	blackout period? (See	interations	<u>10a</u>		<u> </u>		
,	and 29 CF	FR 2520.101-3.)	friend more thinking a					يرب	。 》 》 》 》 》 》 》	7.116
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OCT-15-2012 15:13 HARTSDALE MEDICAL 914 725 7579 P.004

HARTSDALE MEDICAL GROU		13-2843597
FORM 5500-SF	OTHER INCOME (LOSS)	STATEMENT 1
DESCRIPTION		AMOUNT
UNREALIZED APPRECIATION	(DEPR.) ON OTHER ASSETS	-10,238.
TOTAL TO FORM 5500-SF, I	LINE 8B	-10,238.
FORM 5500-SF	BENEFITS PAID	STATEMENT 2
DESCRIPTION		
		AMOUNT
	TICIPANTS OR BENEFICIARIES	AMOUNT 130,465.

STATEMENT(S) 1, 2

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Service Provider Affidavit

I certify that I have been specifically authorized in writing by the plan administrator/employer, as applicable, to enter my EFAST2 PIN on this return/report in order to electronically submit this return/report. I further certify that: (1) | will retain a copy of the administrator's/employer's specific written authorization in my records; (2) I have attached to this electronic filling, in addition to any other regulated achedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 or Form 5500-SF return/report bearing the manual signature of the plan administrator/employer under penalty of perjury; (3) I advised the plan administrator/employer that by selecting this electronic signature option the PDF image of thet manual signature will be included with the rest of the return/report posted by the Department of Labor (DOL) on the internet for public disclosure; and (4) I will communicate to the plan administrator/employer any inquiries and information that I receive from EFAST2, DOL, IRS or PBOC regarding this annual return/report.

1.115/1- Alexandra tele 20012 Date Enter name of Individual signing as service provider

Signature service provider (optional)

118691 85-01-11