# 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

**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: [X] 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: [X] Form 5558 [ ] automatic extension [ ] DFVC program
[ ] special extension (enter description)

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
HARTSDALE MEDICAL GROUP PC

**1b** Three-digit plan number (PN) ▶ 002

**1c** Effective date of plan 01/01/1998

**2a** Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)
HARTSDALE MEDICAL GROUP PC

180 E HARTSDALE AVE
STE 1 E
HARTSDALE, NY 10530

180 E HARTSDALE AVE
STE 1 E
HARTSDALE, NY 10530

**2b** Employer Identification Number (EIN) 13-2843597

**2c** Sponsor's telephone number 914-725-2010

**2d** Business code (see instructions) 621111

**3a** Plan administrator's name and address (if same as plan sponsor, enter "Same")
HARTSDALE MEDICAL GROUP PC

180 E HARTSDALE AVE
STE 1 E
HARTSDALE, NY 10530

**3b** Administrator's EIN 13-2843597

**3c** Administrator's telephone number 914-725-2010

**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** | 12 |
| **b** Total number of participants at the end of the plan year | **5b** | 0 |
| **c** Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) | **5c** | 6 |

**6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] 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.) [X] Yes [ ] 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 | 262415 | 121712 |
| **b** Total plan liabilities | 7b | | |
| **c** Net plan assets (subtract line 7b from line 7a) | 7c | 262415 | 121712 |

| **8** Income, Expenses, and Transfers for this Plan Year | | (a) Amount | (b) Total |
|---|---|---|---|
| **a** Contributions received or receivable from: **(1)** Employers | 8a(1) | | |
| **(2)** Participants | 8a(2) | | |
| **(3)** Others (including rollovers) | 8a(3) | | |
| **b** Other income (loss) | 8b | -10238 | |
| **c** Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | -10238 |
| **d** Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 130465 | |
| **e** Certain deemed and/or corrective distributions (see instructions) | 8e | | |
| **f** Administrative service providers (salaries, fees, commissions) | 8f | | |
| **g** Other expenses | 8g | | |
| **h** Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | 130465 |
| **i** Net income (loss) (subtract line 8h from line 8c) | 8i | | -140703 |
| **j** Transfers to (from) the plan (see instructions) | 8j | | |

## 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 | 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) | **10a** | | X | |
| **b** Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | **10b** | | X | |
| **c** Was the plan covered by a fidelity bond? | **10c** | X | | 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** | | 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.) | **10e** | | X | |
| **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 | |
| **h** If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 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** | | X | |

## 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** 0

**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. | 10/15/2012 | MAXWELL CHAIT |
| | **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
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OMB Nos. 1210-0110
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**2011**

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[ ] an amended return/report [ ] a short plan year return/report (less than 12 months)

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[ ] special extension (enter description)

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1a Name of plan
HARTSDALE MEDICAL GROUP PC

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/1998

2a Plan sponsor's name and address; include room or suite number (employer, if for single-employer plan)
HARTSDALE MEDICAL GROUP PC

180 E HARTSDALE AVE
STE 1 E
HARTSDALE NY 10530

2b Employer Identification Number (EIN) 13-2843597

2c Sponsor's telephone number 914-725-2010

2d Business code (see instructions) 621111

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

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a Sponsor's name

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|---|---|---|---|
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6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] 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.) [X] Yes [ ] 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

| | | | (a) Beginning of Year | (b) End of Year |
|---|---|---|---|---|
| 7 | Plan Assets and Liabilities | | | |
| a | Total plan assets | 7a | 262,415 | 121,712 |
| b | Total plan liabilities | 7b | | |
| c | Net plan assets (subtract line 7b from line 7a) | 7c | 262,415 | 121,712 |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | (b) Total |
| a | Contributions received or receivable from: (1) Employers | 8a(1) | | |
| | (2) Participants | 8a(2) | | |
| | (3) Others (including rollovers) | 8a(3) | | |
| b | Other income (loss) SEE STATEMENT 1 | 8b | -10,238 | |
| c | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | -10,238 |
| d | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 130,465 | STATEMENT 2 |
| e | Certain deemed and/or corrective distributions (see instructions) | 8e | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | | |
| g | Other expenses | 8g | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | 130,465 |
| i | Net income (loss) (subtract line 8h from line 8c) | 8i | | -140,703 |
| j | Transfers to (from) the plan (see instructions) | 8j | | |

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

Form 5500-SF (2011)

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## 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

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## 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.) | 10a | | X | |
| b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | 10b | | X | |
| c Was the plan covered by a fidelity bond? | 10c | X | | 36,579 |
| 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 | | 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.) | 10e | | X | |
| 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 | |
| h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 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 | | X | |

## 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? (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) ☐ Yes ☒ No

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**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

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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 0

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 | Signature of plan administrator | 10/15/2012 Date | MAXWELL CHAIT Enter name of individual signing as plan administrator |
| SIGN HERE | Signature of employer/plan sponsor | 10/15/2012 Date | MAXWELL CHAIT Enter name of individual signing as employer or plan sponsor |

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HARTSDALE MEDICAL GROUP PC 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, LINE 8B | -10,238. |

FORM 5500-SF BENEFITS PAID STATEMENT 2

| DESCRIPTION | AMOUNT |
|---|---|
| PAYMENTS DIRECTLY TO PARTICIPANTS OR BENEFICIARIES | 130,465. |
| TOTAL TO FORM 5500-SF, LINE 8D | 130,465. |

STATEMENT(S) 1, 2

## 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) I will retain a copy of the administrator's/employer's specific written authorization in my records; (2) I have attached to this electronic filing, in addition to any other required schedules 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 that 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 PBGC regarding this annual return/report.

| Signature of service provider (optional) | Date | Enter name of individual signing as service provider |
|---|---|---|
| | 10/15/12 | Aleksandar Milovic, CPA |

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