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).

0040

2012

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

| | | | Complete all entries in acc | ordance with the mon | uctions to the Form 53 | 000-3F. | |
|------------|----------|---|--|-----------------------------|--------------------------|--------------------|---|
| | art I | | Identification Information | | | | |
| For | calenda | ar plan year 2012 or fi | scal plan year beginning 01/01/2 | | and ending | 12/31/2012 | <u>;</u> |
| | | urn/report is for: | X a single-employer plan | 吕 " | plan (not multiemployer |) <u> </u> | a one-participant plan |
| В | This ret | urn/report is: | the first return/report | the final return/repor | | | |
| | | | an amended return/report | a short plan year retu | urn/report (less than 12 | months) | |
| С | Check b | oox if filing under: | Form 5558 | automatic extension | | ∐ [| DFVC program |
| | | | special extension (enter descri | otion) | | | |
| Pa | art II | Basic Plan Info | ormation—enter all requested info | rmation | | | |
| | Name | • | | | | 1b Thr | |
| HAR | ISDALE | E MEDICAL GROUP F | 5 C | | | | n number N) ▶ 002 |
| | | | | | | | ective date of plan |
| | | | | | | | 01/01/1998 |
| | | consor's name and ad E MEDICAL GROUP | Idress; include room or suite number | r (employer, if for a singl | e-employer plan) | 2b Em (EII) | ployer Identification Number N) 13-2843597 |
| | | | | | | 2c Spo | onsor's telephone number |
| | | WOOD RD | | RTSDALE AVE | | | 914-997-5180 |
| STE WHI | | INS, NY 10603-1900 | STE 1 E HARTSDA | ALE, NY 10530 | | 2d Bus | siness code (see instructions) 621111 |
| 3a | Plan a | dministrator's name a | nd address XSame as Plan Sponso | or Name Same as Pl | an Sponsor Address | 3b Adr | ministrator's EIN |
| | | | | | | 3c Adr | ministrator's telephone number |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 4 | If the m | name and/or FINI of the | o plan aparage has shaped since the | a last ratura/rapart filed | for this plan anter the | 46 =0 | |
| 4 | | | e plan sponsor has changed since the mber from the last return/report. | ie iast return/report illed | for this plan, enter the | 4b EIN | 1 |
| а | | or's name | · | | | 4c PN | |
| 5a | Total r | number of participants | at the beginning of the plan year | | | 5а | 12 |
| b | Total r | number of participants | at the end of the plan year | | | 5b | 0 |
| С | | | account balances as of the end of th | | | 5c | 0 |
| 6a | Were | all of the plan's asset | s during the plan year invested in eli | gible assets? (See instru | uctions.) | | X Yes No |
| b | | | f the annual examination and report | | | | V voo □ No |
| | | | ? (See instructions on waiver eligibilities in the fine 6a or line 6b, the plan ca | - | | | |
| Car | | | or incomplete filing of this return/ | | | | |
| | | • • | her penalties set forth in the instruct | • | | | |
| SB | or Sche | | nd signed by an enrolled actuary, as | | | | |
| SIG | SN . | Filed with authorized | /valid electronic signature. | 08/23/2013 | MAXWELL CHAIT | | _ |
| HE | RE | Signature of plan a | ndministrator | Date | Enter name of indiv | idual signing | as plan administrator |
| SIG | iN . | | | | | | • |
| HE | | Signature of emplo | over/nlan snonsor | Date | Enter name of indiv | idual signing | g as employer or plan sponsor |
| | | name (including firm r | name, if applicable) and address; inc | | | | 's telephone number (optional) |
| ALE | XANDE | R ELEZOVIC, CPA | , | | • | | 914-997-5180 |
| | | BLOCH & ELEZOVIO WOOD RD #311 | J LLP | | | | 311 007 0100 |
| | | INS, NY 10603-1900 | | | | | |
| | | | | | | | |

Form 5500-SF 2012 Page **2**

| Do | t III Financial Information | | <u> </u> | | | | |
|------------|--|-------------|----------------------------------|------------|---------|-----------------|-----------------------------------|
| | t III Financial Information | | (a) De atauta a a () (a | | | | (h) Ford of Ween |
| | Plan Assets and Liabilities | _ | (a) Beginning of Yea | | | | (b) End of Year |
| | Total plan assets | 7a | 12171 | 2 | | | 0 |
| | Total plan liabilities | 7b | 40474 | 0 | | | |
| | Net plan assets (subtract line 7b from line 7a) | 7c | 12171 | 2 | | | 0 |
| | Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from: | | (a) Amount | | | | (b) Total |
| а | (1) Employers | 8a(1) | | | | | |
| | (2) Participants | 8a(2) | | | | | |
| | (3) Others (including rollovers) | 8a(3) | | | | | |
| b | Other income (loss) | . 8b | 576 | 66 | | | |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | 5766 |
| d | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 12747 | '8 | | | |
| е | 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 | | | | | 127478 |
| i | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | -121712 |
| j | Transfers to (from) the plan (see instructions) | 8i | | | | | |
| Par | t IV Plan Characteristics | | • | | | | |
| 9a | If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 2T | feature co | des from the List of Plan Char | acteris | stic Co | des in | the instructions: |
| b | If the plan provides welfare benefits, enter the applicable welfare fe | eature cod | les from the List of Plan Chara | cteristi | ic Cod | les in tl | he instructions: |
| Part | V Compliance Questions | | | | | | |
| 10 | During the plan year: | | | | Yes | No | Amarint |
| a | | | | 10a | 100 | X | Amount |
| b | | ? (Do not | include transactions reported | 10b | | X | |
| | | | | | Χ | | |
| | | | | 10c | | | 35000 |
| d | or dishonesty? | | | 10d | | X | |
| е | Were any fees or commissions paid to any brokers, agents, or oth insurance service or other organization that provides some or all cinstructions.) | of the bene | efits under the plan? (See | 10e | | Χ | |
| f | Has the plan failed to provide any benefit when due under the plan | | | 10f | | X | |
| | · · · · · · · · · · · · · · · · · · · | | | | | X | |
| g h | | (See instru | uctions and 29 CFR | 10g 10h | | X | |
| i | If 10h was answered "Yes," check the box if you either provided the | he require | d notice or one of the | | | X | |
| D1 | exceptions to providing the notice applied under 29 CFR 2520.10 | 1-3 | | 10i | | | |
| Part 11 | Is this a defined benefit plan subject to minimum funding requirem | | | | | | |
| 11a | 5500) and line 11a below) Enter the amount from Schedule SB line 39 | | | | | 11a | 165 / 140 |
| 12 | Is this a defined contribution plan subject to the minimum funding | | | | | 302 of | ERISA? Yes X No |
| _ | (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, | • | | | | | |
| а | If a waiver of the minimum funding standard for a prior year is beir granting the waiver. | ng amortiz | ed in this plan year, see instru | | and e | enter th Day | ne date of the letter ruling Year |
| If | you completed line 12a, complete lines 3, 9, and 10 of Schedulo | | | | | | |
| b | Enter the minimum required contribution for this plan year | | | | | 12b | |
| | · | | | _ | | | · |

| | Form 5500-SF 2012 Page 3 - 1 | | | |
|------|--|------------------|------------|---------------------|
| | 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? | | Yes X No | |
| | If "Yes," enter the amount of any plan assets that reverted to the employer this year | . 13a | | |
| b | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the of the PBGC? | control | | Yes X No |
| С | 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): | 1 3c(2) E | IN(s) | 13c(3) PN(s) |
| Part | VIII Trust Information (optional) | | | |
| | Name of trust | 14b ⊤ | rust's EIN | |

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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).

2012

This Form is Open

OMB Nos. 1210-0110

1210-0089

| Pension Benefit Guaranty Corporation P Complete all entries in accordance with the instructions to | the Fo | III 5500-5F. | to Public I | nspection |
|--|---|--|--|-----------------------------|
| Part I Annual Report Identification Information | | | | |
| For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 | and en | ding 12 | 2/31/201 | 12 |
| A This return/report is for: X a single-employer plan a multiple-employer plan (not | multie | mployer) 📙 | a one-participa | ant plan |
| B This return/report is: the first return/report the final return/report | | | | |
| an amended return/report a short plan year return/repo | rt (less | than 12 month | ıs) | |
| C Check box if filling under: Form 5558 automatic extension | | | DFVC program | n |
| special extension (enter description) | | | | |
| Part II Basic Plan Information - enter all requested information | | | | |
| 1a Name of plan | | Three-digit | | |
| HARTSDALE MEDICAL GROUP PC | | pian number (P | 'N) ▶ | 002 |
| | 1c | Effective date o | of plan | |
| | | 01/01 | L/1998 | |
| 2a Plan sponsor's name and address; include room or suite number (employer, if for single-employer plan) | 2b | Employer Identi | | er (EIN) |
| HARTSDALE MEDICAL GROUP PC | | 13-28 | 343597 | |
| | | Sponsor's telep | | |
| 399 KNOLLWOOD RD | 914 | <u>-997-518</u> | 30 | |
| STE 311 | 2d | Business code | | ns) |
| WHITE PLAINS NY 10603-1900 | ļ <u></u> | 62111 | _1 | |
| 3a Plan administrator's name and address X same as Plan Sponsor Name X same as Plan Sponsor Address | 3b , | Administrator's | EIN | |
| | 3с | Administrator's | telephone nur | mber |
| 1 If the name and/ar EIN of the plan appears has abased since the last voture/report filed for this | 4b | EINI | | |
| 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. | 70 | EIIV | | |
| a Sponsor's name | 4c | DNI | · · · · · · | |
| a oportion a frame | 1 0 | T IN | | |
| | | | 10 | |
| 5a. Total number of participants at the beginning of the plan year | 5a | | 12 | |
| 5a Total number of participants at the beginning of the plan year b Total number of participants at the end of the plan year | <u>5a</u> | | 12 | |
| b Total number of participants at the end of the plan year | 5a 5b | | | |
| Total number of participants at the end of the plan year Number of participants with account balances as of the end of the plan year (defined | 5b | | 0 | |
| Total number of participants at the end of the plan year Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) | 5b 5c | | 0 | es No |
| Total number of participants at the end of the plan year Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) Were all of the plan's assets during the plan year invested in eligible assets? (See Instructions.) | 5b 5c | | 0 | es No |
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| Pa | Financial Information | | | | | | | | |
|----------|--|---|--------------|----------|---------|------------|--------------------|---|------------------|
| 7 | Plan Assets and Liabilities | | (a) Be | ginning | of Ye | ar | (| b) End of ` | Year |
| <u>a</u> | Total plan assets | 7a | | 12 | 1,7 | <u>′12</u> | | | 0 |
| <u>b</u> | Total plan liabilities | 7b | | | | | | | |
| <u> </u> | Net plan assets (subtract line 7b from line 7a) | 7с | | 12 | 1,7 | <u>′12</u> | | | 0 |
| <u>8</u> | Income, Expenses, and Transfers for this Plan Year | | (| a) Amo | unt | | | (b) Tota | <u> </u> |
| а | Contributions received or receivable from: | | | | | | | | |
| | (1) Employers | 8a(1) | | | | | _ | | |
| | (2) Participants | 8a(2) | | | | | _ | | |
| | (3) Others (including rollovers) | 8a(3) | | | | | _ | | |
| <u>b</u> | Other income (loss) SEE STATEMENT 1 | 8b | | | 5,7 | 66 | | | |
| С | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | | | 5,766 |
| d | Benefits paid (including direct rollovers and insurance premiums to provide | | | | | | | | |
| | benefits) | 8d | | 12 | 7,4 | 78 | STA | TEMEN. | r. 2 |
| <u>e</u> | Certain deemed and/or corrective distributions (see instructions) | . 8e | | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | . 8f | | | | | _ | | |
| <u>g</u> | Other expenses | . 8g | | | | | | | |
| <u>h</u> | Total expenses (add lines 8d, 8e, 8f, and 8g) | . 8h | | | | | | 1 | 27,478 21,712 |
| <u> </u> | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | | -17 | 21,712 |
| j | Transfers to (from) the plan (see instructions) | . 8j | | | | | | | |
| Pa | rt IV Plan Characteristics | | | | | | | | |
| 9a | If the plan provides pension benefits, enter the applicable pension feature of 2E 2G 2J 2K 2T | codes fro | m the List | of Plan | Chara | acteris | it i c Code | s in the ins | tructions: |
| b | | des fron | the List o | f Plan C | Charac | teristi | c Codes | in the instr | uctions: |
| | et V Compliance Questions | · · · · · · · · · · · · · · · · · · · | | | | | | | |
| 10 | During the plan year: | , | | | Yes | No | | Amount | |
| | Was there a failure to transmit to the plan any participant contributions within the time | pariod do | caribad | Τ' '' | 168 | INO | | Amount | • |
| u | in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Corrections and Policies Fiduciary Co | - | | 10a | | X | | | |
| h | Were there any nonexempt transactions with any party-in-interest? (Do not in | | <u> </u> | IVa | | 23 | | | |
| | transactions reported on line 10a.) | | | 10b | | X | | | |
| | : Was the plan covered by a fidelity bond? | | | 10c | Х | 13 | | | 35,000 |
| | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bor | | ********** | 100 | | <u> </u> | - | | 337000 |
| - | was caused by fraud or dishonesty? | | | 10d | | x | | | |
| Α | Were any fees or commissions paid to any brokers, agents, or other persons | | | 100 | | | | | |
| Ŭ | carrier, insurance service or other organization that provides some or all of the | | | | | | | | |
| | the plan? (See instructions.) | | | 10e | | X | | | |
| f | Has the plan failed to provide any benefit when due under the plan? | | | 10f | | X | ··· | | |
| | Did the plan have any participant loans? (If "Yes," enter amount as of year e | | | 10g | | X | | | |
| | If this is an individual account plan, was there a blackout period? (See instru | | | 1.08 | | | | | |
| | and 29 CFR 2520.101-3.) | | | 10h | | Х | | | |
| í | If 10h was answered "Yes," check the box if you either provided the required | | | 10.1 | | | | | |
| • | of the exceptions to providing the notice applied under 29 CFR 2520.101-3 | | | 10i | | Х | | | |
| Pai | rt VI Pension Funding Compliance | *************************************** | <u> </u> | 101 | | | <u> </u> | *************************************** | |
| 11 | ls this a defined benefit plan subject to minimum funding requirements? (If " | Yes " see | e instructio | ns and | comp | lete | | | |
| | Schedule SB (Form 5500) and line 11a below) | | | | | | | Yes | X No |
| 11a | Enter the amount from Schedule SB line 39 | | | | | 11a | | 1100 | |
| 12 | Is this a defined contribution plan subject to the minimum funding requirements of sec | | | | | | A? | Yes | X No |
| | (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applica | | | | | | | 1 1 . 5 . 5 | |
| а | If a walver of the minimum funding standard for a prior year is being amortize | | plan vear | see ins | tructio | ns. ar | nd enter t | he date of | the letter |
| | ruling granting the waiver. | | Month | 1110 | Day | | .s onto | Year | |
| lf | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Forn | | | o line 1 | | , | | | - |
| | Enter the minimum required contribution for this plan year | | | | | 12b | | | |
| | The second secon | | | | | | | | |

| Form 5500-SF (2012) | Page 3- | |
|---|--|-------------------|
| | | |
| 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) | | |
| e Will the minimum funding amount reported on line 12d be met by the funding dead | | s 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? | Ye: | s X No |
| If "Yes," enter the amount of any plan assets that reverted to the employer this yea | ar 13a | |
| b Were all the plan assets distributed to participants or beneficiaries, transferred to a | | , |
| under the control of the PBGC? | | Yes X No |
| c If during this plan year, any assets or liabilities were transferred from this plan to an | other plan(s), identify the plan(s) to | o which assets or |
| liabilities were transferred. (See instructions.) | | |
| 13c(1) Name of plan(s): | 13c(2) EIN(s) | 13c(3) PN(s) |
| | | |
| | | |
| Part VIII Trust Information (optional) | | |
| 14a Name of trust | 14b Trust's El | N |
| | | |
| | | |
| | | |

| FORM 5500-SF | OTHER INCOME (LOSS) | STATEMENT | | | | |
|-----------------------------|--------------------------|-----------|--|--|--|--|
| DESCRIPTION | | TRUOMA | | | | |
| UNREALIZED APPRECIATION (D) | 5,766. | | | | | |
| TOTAL TO FORM 5500-SF, LINI | E 8B | 5,766 | | | | |
| FORM 5500-SF | BENEFITS PAID | STATEMENT | | | | |
| DESCRIPTION | | TRUOMA | | | | |
| PAYMENTS DIRECTLY TO PARTIC | CIPANTS OR BENEFICIARIES | 127,478 | | | | |
| TOTAL TO FORM 5500-SF, LINE | 127,478. | | | | | |