

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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2013</div> This Form is Open to Public Inspection
---	--	---

Part I Annual Report Identification Information			
For calendar plan year 2013 or fiscal plan year beginning <u>01/01/2013</u> and ending <u>12/31/2013</u>			
A	This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) <input type="checkbox"/> a one-participant plan	
B	This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)	
C	Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)	

Part II Basic Plan Information —enter all requested information			
1a	Name of plan <u>FREEPORT PAIN MANAGEMENT</u>	1b	Three-digit plan number (PN) ► <u>001</u>
		1c	Effective date of plan <u>01/01/2010</u>
2a	Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>FREEPORT PAIN MANAGEMENT MEDICAL PC</u> <u>31 GUY LOMBARDO AVE</u> <u>FREEPORT, NY 11520</u>	2b	Employer Identification Number (EIN) <u>26-4513707</u>
		2c	Sponsor's telephone number <u>201-304-4147</u>
		2d	Business code (see instructions) <u>621111</u>
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	3b	Administrator's EIN
		3c	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
5a	Total number of participants at the beginning of the plan year	5a	<u>6</u>
b	Total number of participants at the end of the plan year	5b	<u>6</u>
c	Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c	
6a	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.			
c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not determined	

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.	08/06/2014	NIDIA CARRERO MD
	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
Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)			Preparer's telephone number (optional)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	41313	57455
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	41313	57455
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	15990	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	152	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		16142
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
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		0
i Net income (loss) (subtract line 8h from line 8c)	8i		16142
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:
1A 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:
4B

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)		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)		X	
c Was the plan covered by a fidelity bond?		X	
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		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.)		X	
f Has the plan failed to provide any benefit when due under the plan?		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
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			

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) and line 11a below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39	11a 0
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ..	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(If "Yes," complete line 12a or lines 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)

Part VIII Trust Information (optional)

14a Name of trust	14b Trust's EIN
--------------------------	------------------------

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2013 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>FREEPORT PAIN MANAGEMENT</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>FREEPORT PAIN MANAGEMENT MEDICAL PC</u>	D Employer Identification Number (EIN) <u>26-4513707</u>
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

Part I	Basic Information
1 Enter the valuation date: Month _____ Day _____ Year _____	
2 Assets:	
a Market value	2a <u>40733</u>
b Actuarial value	2b <u>40733</u>
3 Funding target/participant count breakdown:	
a For retired participants and beneficiaries receiving payment.....	3a <u>0</u>
b For terminated vested participants.....	3b <u>2</u>
c For active participants:	
(1) Non-vested benefits	3c(1) <u>1677</u>
(2) Vested benefits	3c(2) <u>108807</u>
(3) Total active.....	3c(3) <u>4</u>
d Total.....	3d <u>6</u>
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>	
a Funding target disregarding prescribed at-risk assumptions	4a
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	4b
5 Effective interest rate	5 <u>6.37 %</u>
6 Target normal cost	6 <u>0</u>

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	
Signature of actuary <u>JOHN GARIGLIANO</u>	Date <u>14-03634</u>
Type or print name of actuary <u>FOREST HILLS PENSION SERVICES</u>	Most recent enrollment number <u>631-870-6824</u>
Firm name <u>200 BROADHOLLOW RD MELVILLE, NY 11747</u>	Telephone number (including area code)
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2013
v. 130118

Part II Beginning of Year Carryover and Prefunding Balances		
	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>0.00</u> %		
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		9059
b Interest on (a) using prior year's effective interest rate of <u>7.07</u> % except as otherwise provided (see instructions)		640
c Total available at beginning of current plan year to add to prefunding balance		9699
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages		
14 Funding target attainment percentage	14	35.16 %
15 Adjusted funding target attainment percentage	15	35.16 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	22.73 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	35.16 %

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
02/25/2014	704		07/07/2014	500	
04/25/2014	17				
05/20/2014	6500				
05/29/2014	14				
06/12/2014	2680				
06/17/2014	5576				
			Totals ►	18(b)	15991
					18(c)
					0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	14285
20 Quarterly contributions and liquidity shortfalls:		
a Did the plan have a "funding shortfall" for the prior year?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c If line 20a is "Yes," see instructions and complete the following table as applicable:		

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.94%	2nd segment: 6.15%	3rd segment: 6.76 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code).....				21b 0
22 Weighted average retirement age				22 62
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6).....	31a	0	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment.....	75103	13511	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)...	34	13511	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....	0	0	0
36 Additional cash requirement (line 34 minus line 35).....	36	13511	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	14285	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	774	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b		
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected	<input type="checkbox"/> 2 plus 7 years <input checked="" type="checkbox"/> 15 years		
b Eligible plan year(s) for which the election in line 41a was made	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input checked="" type="checkbox"/> 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

**SCHEDULE SB
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2013**This Form is Open to Public
Inspection**For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013▶ **Round off amounts to nearest dollar.**▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

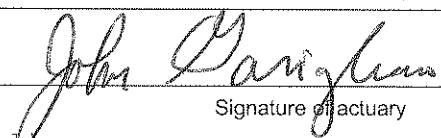
A Name of plan Freeport Pain Management		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Freeport Pain Management Medical PC		D Employer Identification Number (EIN) 26-4513707
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		

Part I Basic Information

1 Enter the valuation date: Month <u>1</u> Day <u>1</u> Year <u>2013</u>			
2 Assets:			
a Market value		2a	40,733
b Actuarial value		2b	40,733
3 Funding target/participant count breakdown:			
		(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment.....		3a	0
b For terminated vested participants.....		3b	2
c For active participants:			
(1) Non-vested benefits		3c(1)	1,677
(2) Vested benefits		3c(2)	108,807
(3) Total active.....		3c(3)	4
d Total.....		3d	6
4 If the plan is in at-risk status, check the box and complete lines (a) and (b). <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....		4b	
5 Effective interest rate		5	6.37 %
6 Target normal cost		6	0

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

**SIGN
HERE**

Signature of actuary

John Garigliano

Type or print name of actuary

Forest Hills Pension Services

Firm name

200 Broadhollow Rd

Melville

NY 11747

Address of the firm

7/30/14

Date

14-03634

Most recent enrollment number

(631) 870-6824

Telephone number (including area code)

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2013
v. 130118

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>0.00</u> %		
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		9,059
b Interest on (a) using prior year's effective interest rate of <u>7.07</u> % except as otherwise provided (see instructions)		640
c Total available at beginning of current plan year to add to prefunding balance		9,699
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	35.16 %
15 Adjusted funding target attainment percentage	15	35.16 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	22.73 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	35.16 %

Part IV Contributions and Liquidity Shortfalls

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
02/25/2014	704		07/07/2014	500	
04/25/2014	17				
05/20/2014	6,500				
05/29/2014	14				
06/12/2014	2,680				
06/17/2014	5,576				
Totals ►			18(b)	15,991	18(c)
					0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	14,285

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☒ No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:			
a Segment rates:	1st segment: 4.94 %	2nd segment: 6.15 %	3rd segment: 6.76 %
			<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code).....			21b 0
22 Weighted average retirement age			22 62
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute			

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment		27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)		31a	0
b Excess assets, if applicable, but not greater than line 31a		31b	0
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment.....	75,103	13,511	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount		33	
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) ..		34	13,511
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....	0	0	0
36 Additional cash requirement (line 34 minus line 35).....	36	13,511	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	14,285	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)		38a	774
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances		38b	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected <input type="checkbox"/> 2 plus 7 years <input checked="" type="checkbox"/> 15 years			
b Eligible plan year(s) for which the election in line 41a was made <input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input checked="" type="checkbox"/> 2011			
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

Schedule SB, line 19 - Discounted Employer Contributions

Interest Rates for Contribution Year End Date: 12/31/2013

Effective: 6.37%

Late Quarterly: 11.37%

<u>Effective Date</u>	<u>Amount</u>	<u>Effective Interest</u>	<u>Quarterly Interest</u>	<u>Discounted</u>
02/25/2014	\$704	-48	-26	\$630
04/25/2014	\$17	-1	-1	\$15
05/20/2014	\$6,500	-531	-240	\$5,729
05/29/2014	\$14	-1	-1	\$12
06/12/2014	\$2,680	-229	-64	\$2,387
06/17/2014	\$5,576	-480	-39	\$5,057
07/07/2014	\$500	-45	0	\$455
	<hr/> \$15,991			<hr/> \$14,285

Name of Plan: Freeport Pain Management
Plan Sponsor's EIN: 26-4513707
Plan Number: 001
Plan Sponsor's Name: Freeport Pain Management Medical PC

Schedule SB, Part V - Statement of Actuarial Assumptions

Target Assumptions:

Male Nonannuitant: 2013 Nonannuitant Male
 Female Nonannuitant: 2013 Nonannuitant Female
 Male Annuitant: 2013 Annuitant Male
 Female Annuitant: 2013 Annuitant Female
 Applicable months from valuation month: 0
 Probability of lump sum: 100.00%
 Use pre-retirement mortality: No

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Segment rates:	1.62	4.40	5.45
High Quality Bond rates:	N/A	N/A	N/A
Final rates:	1.62	4.40	5.45
Override:	4.94	6.15	6.76

Salary Scale

Male: 0.00%
 Female: 0.00%

Withdrawal

Male: None
 Female: None

Withdrawal-Select

Male: None
 Female: None

Early Retirement Rates

Male: None
 Female: None

Subsidized Early Retirement Rates

Male: None
 Female: None

Options:

Use optional combined mortality table for small plans: Yes
 Use discount rate transition: No
 Lump sums use proposed regulations: Yes

Actuarial Equivalent Floor

Stability period: plan year
 Lookback months: 1
 Nonannuitant: None
 Annuitant: 2013 Applicable

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Current:	1.00	3.57	4.77
Override:	0.00	0.00	0.00

Late Retirement Rates

Male: None
 Female: None

Marriage Probability

Male: 0.00%
 Female: 0.00%
 Expense loading: 0.00%

Setback

0

Disability Rates

Male: None
 Female: None

Mortality

Male: None
 Female: None

Setback

0
 0

Name of Plan: Freeport Pain Management
 Plan Sponsor's EIN: 26-4513707
 Plan Number: 001

Schedule SB, Part V - Summary of Plan Provisions

Eligibility Requirements

Age (yrs) : 21
 Age (months) : 0
 Wait (months) : 12
 Two year eligibility : No

Service/Participation Requirements

Definition of years: Hours worked
 Continuing hours: 1,000
 Excluded classes: Union Members
 Non-resident alien

Earnings

Total compensation excluding : 403(b)
 Cafeteria
 Other
 Prior to participation
 415 prior to participation

<u>Retirement</u>	<u>Normal</u>	<u>Early</u>	<u>Subsidized Early</u>	<u>Disability</u>	<u>Death</u>
Age:	62				
Service:	0				
Participation:	5				
Defined:	1st of month during				

Benefit Reduction / Mortality table & setback

Male:	Actuarial Equivalence	Actuarial Equivalence	None	0
Female:	Actuarial Equivalence	Actuarial Equivalence	None	0
Rates - Male:	None	None	None	
Rates - Female:	None	None	None	

Use Social Security Retirement Age:	No	REACT Benefits Percentage:	50.00%
Vesting Schedule:	2/20	Pre-retirement death benefit	
Vesting Definition:	Hours Worked	Percentage of accrued benefit:	100.00%
		Death Benefit Payment method:	Face + PVAB - Curr. CV

	<u>Annuity</u>	<u>Percent</u>	<u>Years</u>
Normal:	Life only	0.00%	0
QJSA:	Joint and contingent	50.00%	0

Significant Changes in Plan Provisions Since Last Valuation

Name of Plan: Freeport Pain Management
 Plan Sponsor's EIN: 26-4513707
 Plan Number: 001

Schedule SB, Part V - Summary of Plan Provisions

Benefits

Pension Formula: Benefit formula
 Type of Formula: Flat benefit
 Effective Date: 01/01/2006

Flat benefit non-integrated type: Percent
 Total percent of salary: 35.75%
 Dollar amount: None
 Reduction based on: Accrual
 Benefit reduction for years less than: 25

Averaging

Projection method:	Current Compensation	Apply exclusion to accrued benefit:	No
Based on:	Final Average	Annualize short compensation years:	No
Highest:	3	Annualize short plan years:	No
In the last:	10	Include compensations based	
Excluding:	0	on years of:	Accrual

Accrual

Frozen: Yes
 Definition of years: Hours worked
 Fractions based on: N/A

Accrual credit:	<u>Continuing</u>	<u>Died</u>	<u>Disabled</u>	<u>Retired</u>	<u>Terminated</u>	Precision:	N/A
	1000	0	0	0	0	Limit current credit	
						to:	N/A

Years based on:	Service	Cap/floor years:	0
Maximum past accrual years:	5.0000	Cap or floor:	Floor
Method:	Fractional	Accrual % per year:	0.00%
		Apply 415 before accrual:	With accrued 415 limit

Name of Plan: Freeport Pain Management
 Plan Sponsor's EIN: 26-4513707
 Plan Number: 001

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 4085 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 2013 This Form is Open to Public Inspection
---	--	--

Part I Annual Report Identification Information			
For calendar plan year 2013 or fiscal plan year beginning		01/01/2013	and ending
		12/31/2013	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer)	<input type="checkbox"/> a one-participant plan
B This return/report is:	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report	
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)	
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
	<input type="checkbox"/> special extension (enter description)		

Part II Basic Plan Information—enter all requested information	
1a Name of plan Freeport Pain Management	1b Three-digit plan number (PN) 001 1c Effective date of plan 01/01/2010
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) Freeport Pain Management Medical PC 31 Guy Lombardo Ave Freeport NY 11520	2b Employer Identification Number (EIN) 26-4513707
	2c Sponsor's telephone number (201) 304-4147
	2d Business code (see instructions) 621111
	3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address
	3b Administrator's EIN 3c 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. a Sponsor's name	4b EIN 4c PN
5a Total number of participants at the beginning of the plan year	5a 6
b Total number of participants at the end of the plan year	5b 6
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.) If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not determined

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		8/14/14	Nidia Correro MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)			Preparer's telephone number (optional)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	41,313	57,455
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	41,313	57,455
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	15,990	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	152	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		16,142
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
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		0
i Net income (loss) (subtract line 8h from line 8c)	8i		16,142
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:
1A 3D
- b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:
4B

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	
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		
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		

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) and line 11a below) ☒ Yes ☐ No

11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 11a 0

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 line 12a or lines 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 0

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	13a	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," enter the amount of any plan assets that reverted to the employer this year		
		0
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)

Part VIII Trust Information (optional)

14a Name of trust	14b Trust's EIN

PN: 001