Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Department of Labor

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

2018

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information	1						
For calendar	plan year 2018 or fis	scal plan year beginning 01/01/2	2018		and ending 12	2/31/201	18		
A This retu	n/report is for:	X a single-employer plan			an (not multiemployer) (ployer information in ac		_		
	·	a one-participant plan	_	foreign plan	, ,,			,	
B This return	n/report is	the first return/report	the	e final return/report					
		an amended return/report	a s	short plan year return	/report (less than 12 m	onths)			
C Check bo	x if filing under:	X Form 5558	au	tomatic extension		DFV	C program		
		special extension (enter desc	' '						
Part II	Basic Plan Info	rmation—enter all requested in	nformatio	on					
1a Name of LONG ISLAND	•	CONSULTANTS, P.C. CASH BAL	_ANCE I	PENSION PLAN II		р	hree-digit lan number PN)	006	
						1c E	Effective date o	f plan 1/2016	
		yer, if for a single-employer plan)				2 b ⊟	mployer Identi	fication Number	
		n, apt., suite no. and street, or P.C e, country, and ZIP or foreign post		(if foreign, see instru	uctions)			566918	
•		CONSULTANTS, P.C.			,	2c S	ponsor's telep 516-466		
						2d B	usiness code ((see instructions)	
600 NORTHER GREAT NECK	RN BLVD., SUITE 21 , NY 11021	6					6211	11	
3a Plan adr	ninistrator's name an	d address 🛛 Same as Plan Spo	nsor.			3b A	dministrator's	EIN	
3c. Admir							dministrator's	telephone number	
								•	
4 If the na	me and/or EIN of the	plan sponsor or the plan name h	nas chan	naed since the last re	eturn/report filed for	4b E	IN		
this plar	n, enter the plan spor	nsor's name, EIN, the plan name a							
a Sponsorc Plan Na						4d F	'N		
5a Total nu	mber of participants	at the beginning of the plan year.				5a		35	
		at the end of the plan year				5b		42	
		account balances as of the end of				5с			
d(1) Total	number of active par	ticipants at the beginning of the p	olan year	٢		5d(1	-	34	
		ticipants at the end of the plan ye				5d(2	2)	40	
than 10	00% vested	terminated employment during the				5e		0	
		or incomplete filing of this retur							
SB or Sched		ner penalties set forth in the instrund signed by an enrolled actuary, ablete.							
0.0	Filed with authorized/	valid electronic signature.		07/25/2019	MICHAEL J. WILEY				
HERE	Signature of plan a	dministrator		Date	Enter name of individ	ual sign	ing as plan adr	ministrator	
SIGN									
HERE	Signature of employ	yer/plan sponsor		Date	Enter name of individ	ual sign	ing as employe	er or plan sponsor	

Form 5500-SF (2018) Page **2**

_										
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)									
С	If the plan is a defined benefit plan, is it covered under the PBGC in If "Yes" is checked, enter the My PAA confirmation number from the	nsurance p	rogram (see ERISA se	ection 4	021)?	X	Yes No	Not determined (See instructions.)		
Pai	t III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning (of Year			(b) End	of Year		
a	Total plan assets	. 7a	178	87244				3455940		
<u>b</u>	Total plan liabilities	7b								
	Net plan assets (subtract line 7b from line 7a)	7c	178	87244				3455940		
	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t	_		(b)	Total		
а 	Contributions received or receivable from: (1) Employers	8a(1)	169	94466						
	(2) Participants	8a(2)								
	(3) Others (including rollovers)	8a(3)								
	Other income (loss)	8b	-2	25770						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						1668696		
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d								
	Certain deemed and/or corrective distributions (see instructions)	8e								
	Administrative service providers (salaries, fees, commissions)	8f								
	Other expenses	8g			_			_		
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						0		
	Net income (loss) (subtract line 8h from line 8c)	8i						1668696		
	Transfers to (from) the plan (see instructions)	8j								
	t IV Plan Characteristics	f t	des from the Pet of Di	01			ada a ta da a ta a	(
9a	If the plan provides pension benefits, enter the applicable pension 1C 3D									
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	es from the List of Plan	n Chara	acterist	ic Cod	des in the instr	uctions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Amount		
а	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	10a		X				
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	t? (Do not	include transactions	10b		X				
С	Was the plan covered by a fidelity bond?			10c	X			700000		
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		X				
e	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	ne or all of	the benefits under	10e		X				
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		X				
g				10g		X				
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)	•		10h						
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i						

Form 5500-SF (2018)	Page 3 -	1

Part	VI Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sche (Form 5500) and line 11a below)		B 	X Yes	s No			
11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40								
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 line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver			of the letter r _ Year	uling			
lf y	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						
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 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 control 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 plan(s) which assets or liabilities were transferred. (See instructions.)	to						
1	3c(1) Name of plan(s): 13c(2)	EIN(s)		13c(3) F	PN(s)			

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

2018

This Form is Open to Public Inspection

<u> Fo</u>	r calendar plan year 2018 or fiscal plan year beginning 01/01/2018		and ending	g 12/3	31/2018	
	Round off amounts to nearest dollar. Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reason	nable caus	se is established	1 .		
Α	Name of plan LONG ISLAND VITREORETINAL CONSULTANTS, P.C. CASH BALANCE PENSION I		B Three-dig plan num	git) •	006
	Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF LONG ISLAND VITREORETINAL CONSULTANTS, P.C.		D Employer	Identification	ation Number (E	IN)
E	Type of plan: Single Multiple-A Multiple-B	an size: X	100 or fewer	101-	500 More th	an 500
P	Part I Basic Information					
1	Enter the valuation date: Month 01 Day 01 Year 2	018				
2	Assets:					
	a Market value			2a		1786924
	b Actuarial value			2b		1786924
3	Funding target/participant count breakdown	\ /	Number of rticipants	. ,	sted Funding Target	(3) Total Funding Target
	a For retired participants and beneficiaries receiving payment		0		0	0
	b For terminated vested participants		1		580	580
	C For active participants		34		1332663	1332663
	d Total		35		1333243	1333243
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)					
	a Funding target disregarding prescribed at-risk assumptions			4a		
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for pla at-risk status for fewer than five consecutive years and disregarding loading factor			4b		
5	Effective interest rate			5		5.58 %
6	Target normal cost			6		1054436
	To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements at accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into accombination, offer my best estimate of anticipated experience under the plan. SIGN					
	HERE				07/24/2019	9
	Signature of actuary				Date	
J	EFFREY F. HARTMANN, FSA, MSPA				17-02699	
	Type or print name of actuary			Most i	recent enrollmer	it number
K	RAVITZ, LLC				818-995-61	
	Firm name 6030 VENTURA BLVD, SUITE 200 NCINO, CA 91436		Te	lephone	number (includi	ng area code)
	Address of the firm		=			
	e actuary has not fully reflected any regulation or ruling promulgated under the statute in uctions	n completi	ng this schedule	e, check	the box and see	;

Page 2 -	1
----------	---

Schedule SB (Form 5500) 2018	Page 2 - [

Part II Beginning of Year Carryover and Prefunding Balances			
(a) Carryover balance	(b) F	refundir	ng balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)			0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)			0
9 Amount remaining (line 7 minus line 8)			0
10 Interest on line 9 using prior year's actual return of			0
11 Prior year's excess contributions to be added to prefunding balance:			
a Present value of excess contributions (line 38a from prior year)			440829
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of			24907
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return			0
C Total available at beginning of current plan year to add to prefunding balance			465736
d Portion of (c) to be added to prefunding balance			0
			0
12 Other reductions in balances due to elections or deemed elections			0
			0
Part III Funding Percentages		4.4	404.000/
14 Funding target attainment percentage		14	134.02%
15 Adjusted funding target attainment percentage		15	134.02%
Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce year's funding requirement	ce current	16	121.24%
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage		17	%
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)	(0	Amou emplo	nt paid by byees
09/12/2018 1200000 0			
09/28/2018 452396 0			
04/08/2019 42070 0			
Totals ► 18(b) 16944	.66 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			0
b Contributions made to avoid restrictions adjusted to valuation date			0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date			1629364
20 Quarterly contributions and liquidity shortfalls:			
a Did the plan have a "funding shortfall" for the prior year?			Yes X 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:			ш
Liquidity shortfall as of end of quarter of this plan year			
(1) 1st (2) 2nd (3) 3rd		(4) 4th	1

F	Part V Assumptions Used to Determine Fun	ding Target and Targ	et Normal Cost		
21	Discount rate:				
	a Segment rates: 1st segment: 3.92%	2nd segment: 5.52%	3rd segment: 6.29 %		N/A, full yield curve used
	b Applicable month (enter code)			21b	0
22	Weighted average retirement age			22	63
23	Mortality table(s) (see instructions) Prior regulation:	Prescribed - combi		- separat	te Substitute
	Current regulation:	Prescribed - combi	ned Prescribed	- senarat	te Substitute
		A Tresembed Combi	Trescribed	Зорага	oubstitute
Pa	art VI Miscellaneous Items				
24	Has a change been made in the non-prescribed actuarial as attachment.		•		_
25	Has a method change been made for the current plan year?	? If "Yes," see instructions re	egarding required attach	ment	Yes X No
26	Is the plan required to provide a Schedule of Active Participa	ants? If "Yes," see instruction	ons regarding required a	ttachmen	tX Yes No
27	If the plan is subject to alternative funding rules, enter applic		ons regarding	27	
P	art VII Reconciliation of Unpaid Minimum R		s For Prior Years		
28	Unpaid minimum required contributions for all prior years			28	0
29	Discounted employer contributions allocated toward unpaid (line 19a)	•		29	0
30	Remaining amount of unpaid minimum required contribution	ns (line 28 minus line 29)		30	0
Pa	art VIII Minimum Required Contribution For	Current Year			
31	Target normal cost and excess assets (see instructions):				
	a Target normal cost (line 6)			31a	1054436
	b Excess assets, if applicable, but not greater than line 31a			31b	453681
32	Amortization installments:		Outstanding Balar	nce	Installment
	a Net shortfall amortization installment			0	0
	b Waiver amortization installment			0	0
33	If a waiver has been approved for this plan year, enter the d (Month Day Year)			33	
34	Total funding requirement before reflecting carryover/prefun	iding balances (lines 31a - 3	1b + 32a + 32b - 33)	34	600755
		Carryover balance	Prefunding balan	се	Total balance
35	Balances elected for use to offset funding requirement	0		0	0
36	Additional cash requirement (line 34 minus line 35)			36	600755
37	Contributions allocated toward minimum required contributions		·	37	1629364
38	Present value of excess contributions for current year (see i	instructions)		<u> </u>	
	a Total (excess, if any, of line 37 over line 36)			38a	1028609
	b Portion included in line 38a attributable to use of prefunding	ng and funding standard car	ryover balances	38b	0
39	Unpaid minimum required contribution for current year (exce	ess, if any, of line 36 over lin	e 37)	39	0
40	Unpaid minimum required contributions for all years			40	0
Pa	rt IX Pension Funding Relief Under Pensi	on Relief Act of 2010	(See Instructions)	-
41	If an election was made to use PRA 2010 funding relief for the	his plan:			
	a Schedule elected	-		Г	2 plus 7 years 15 years
	b Eligible plan year(s) for which the election in line 41a was				08

ATTACHMENT TO 2018 SCHEDULE SB (FORM 5500)

Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II EIN/PN: 11-2566918 / 006

Line 26 - Schedule of Active Participant Data

		YEARS OF CREDITED SERVICE																			
	Un	der 1	1	to 4	5	to 9	10	to 14	15	to 19	20	to 24	25	to 29	30	to 34	35	to 39	40	& up	
Attained		Avg		Avg		Avg		Avg		Avg		Avg		Avg		Avg		Avg		Avg	
Age	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	No.	Comp	Total
Under 25			1																		1
25 to 29			7		3																10
30 to 34			4		4																8
35 to 39					3																3
40 to 44					2																2
45 to 49			1		4																5
50 to 54					1																1
55 to 59					1																1
60 to 64					1																1
65 to 69					2																2
70 & up																					
Total			13		21																34

LONG ISLAND VITREORETINAL CONSULTANTS, P.C. CASH BALANCE PENSION PLAN II EIN 11-2566918 Plan Number 006

Schedule SB, Part V -- Statement of Actuarial Assumptions/Methods

Valuation Date First day of the plan year.

Current valuation date is January 1, 2018.

Unit credit. Actuarial Method

Actuarial Assumptions

Interest Rates per annum, compounded annually (use the rate for each participant based upon the date of payment being valued)

	90% of	24-month	Spot
	25-Year averages	averages	rates
	(minimum funding)	(maximum)	(PBGC)
First 5 Years after valuation date	3.92%	1.81%	2.33%
Next 15 Years	5.52%	3.68%	3.55%
More than 20 years after val date	6.29%	4.53%	4.11%

First column, based on 25-year averages, is used to determine AFTAP and minimum contributions. Second column, based on 24-month averages, is used to determine maximum deductible contributions. Third column, based on spot interest rates, is used to determine PBGC standard target liabilities.

The interest rates above are from the set of interest rates prescribed in the Pension Protection Act of 2006, the Highway and Transportation Funding Act of 2014, and the Moving Ahead for Progress in the 21st Century Act, as published in periodic IRS notices.

-- Accumulation Rate (for account annuities)

3% per annum compounded annually, for current and all earnings and converting balances to future years. This rate and 94 GAR mortality table are used to convert balances to annuities.

- Experience - Active Employees

-- Retirement Age.

-- Death None.

-- Other Separation None.

-- Earnings Progression None.

Compensation is based on expected Pay for the current year.

Retired Mortality

-- Conversion to Annuities 1994 Group Annuity Reserving (94 GAR) unisex table

projected to 2002.

-- Funding RP-2014 combined Mortality tables for males and females,

projected to 2018

The mortality rates for Funding are from the mortality tables prescribed in federal regulations and notices, as authorized by the Pension Protection Act of 2006.

- Form of Payment Lump Sum.

Expense Loading None.

- Asset Valuation Basis Market Value, including discounted contributions

receivable.

Notice to Plan Sponsor about the selection of Interest Rate assumptions and Asset valuation:

The Pension Protection Act of 2006 prescribes that the above segment interest rates will be used as a default unless the Plan Sponsor notifies the actuary that he elects to use different assumptions:

- a. The above segment interest rates represent the rates for the month prior to the valuation date. The Plan Sponsor may elect to use rates applicable to 1 to 4 months prior to the latest month.
- b. Assets are valued at fair market value, without any averaging. The Plan Sponsor may ask the actuary to use an average asset value over up to 24 months.

The Plan Sponsor should notify us immediately if any of these alternative elections are desired.

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

v.171027

2018

This Form is Open to Public Inspection

For calcular plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018 A This return/report is for: a one-participant plan a one-participant plan lat of participating employer information in accordance with the form instructions.) a foreign plan an employer plan an employer plan lat of participating employer information in accordance with the form instructions.) a foreign plan an employer an employer plan an employer an employe		rt Identification Information			221221	2010
A This return/report is for: a one-participant plan a foreign plan a foreign plan a foreign plan a foreign plan B This return/report is the first return/report an amended return/report a short plan year return/report (less than 12 months)	For calendar plan year 2018 or	fiscal plan year beginning	01/01/2018	and ending		
B This return/report is	A This return/report is for:	X a single-employer plan				
the first return/report the final return/report (less than 12 months) DFVC program an anended return/report a short plan year return/report (less than 12 months)		a one-participant plan	a foreign plan			
C Check box if filing under: Form 5558 automatic extension DFVC program Part II Basic Plan Information—enter all requested information 1a Name of plan Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II 2a Plan sponsor's name (employer, if for a single-employer plan) 1c Effective date of plan City or town, stale or province, county, and ZIP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 2b Employer Identification Number (EIN) 11 - 2566918 2c Sponsor's telephone number 516-466-0330 2d Business code (see instructions) 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report, a Sponsor's name 2 Fina Name 5a Total number of participants at the beginning of the plan year 5b 42 2 Number of participants at the beginning of the plan year 5b 42 2 Number of participants at the beginning of the plan year 5c 5d 45 2 Number of participants at the beginning of the plan year 5d 45 2 Number of participants at the beginning of the plan year 5d 45 3 Total number of participants at the beginning of the plan year 5d 45 4 Number of participants at the beginning of the plan year 5d 45 5 Total number of participants at the beginning of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of participants at the beginning of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of participants at the end of the plan year 5d 45 6 Number of p	B This return/report is	the first return/report	the final return/report			
Special extension (enter description) Part II Basic Plan Information—enter all requested information Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II Different Plan II		an amended return/report	a short plan year retui	rn/report (less than 12 n	nonths)	
Special extension (enter description) Part II Basic Plan Information—enter all requested information Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II Different Plan II	C Check box if filing under:	Form 5558	automatic extension		□ DFVC progra	ım
Part II Basic Plan Information—enter all requested information 1a Name of plan Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II					_ =: . o b.o3.o	
18 Name of plan Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZiP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 600 Northern Blvd., Suite 216 Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. A Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year	Part II Basic Plan Int					
Long Island Vitreoretinal Consultants, P.C. Cash Balance Pension Plan II Discrete Pla		omer an requested in	TOTAL COLUMN TOTAL		1b Three-dig	it
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 600 Northern Blvd., Suite 216 Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year C Number of participants at the end of the plan year c number of participants with account balances as of the end of the plan year c Number of participants with account balances as of the end of the plan year d(1) Total number of active participants at the beginning of the plan year e Number of participants with account balances as of the end of the plan year e Number of participants with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year d(1) Total number of active participants at the beginning of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of the plan year with account balances as of the end of	Long Island Vitr	eoretinal Consultants	s, P.C. Cash Bala	ance Pension	plan numb	per
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing addrass (includer oom, apt., suite no. and street, or P.O. Box) City or fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 600 Northern Blvd., Suite 216 Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(1) Total number of active participants at the beginning of the plan year E Number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested E Number of participants with terminated employment during the plan year with accrued benefits that were less than 100% vested Signature of land plants and the plan sponsor C Sution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Violet Age Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	IIan II				()	date of plan
Mailing address (include room, apt, suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 600 Northern Blvd., Suite 216 Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. 5b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) d(1) Total number of active participants at the beginning of the plan year Schedule SB or Schedule MB completed and signed by an enrolled activary, as well as the electronic version of this return/report, and to the best best believed and signed by an enrolled activary, 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 Signature of employer/plan sponsor					-	
City of town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Long Island Vitreoretinal Consultants, P.C. 20 Sponsor's telephone number 516-466-0390 20 Business code (see instructions) 21 Business code (see instructions) 32 Plan administrator's name and address Same as Plan Sponsor. 33 Administrator's EIN 34 Administrator's telephone number this plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 4 Sponsor's same 5 Plan Name 5 Total number of participants at the beginning of the plan year. 5 Total number of participants at the end of the plan year. 5 Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4 (1) Total number of active participants at the end of the plan year. 5 C C Winder of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 5 C Sudin A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. 5 C Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. 5 C Sudin A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. 5 C Sudin A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. 5 C Sudin A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. 5 C Sudin A penalty for the late or incomp						
Signature of employer/plal sponsor Date Enter name of individual signing as plan asponsor of the plan sponsor Date Enter name of individual signing as plan asponsor of the plan sponsor Signature of employer/plal sponsor Date Enter name of individual signing as plan asponsor Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as plan administrator Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Date Enter name of individual signing as employer or plan sponsor Signature of employer/plal sponsor Signatu	City or town, state or proving	nce, country, and ZIP or foreign pos	stal code (if foreign, see inst	ructions)	-	
Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number activity plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 5a Sponsor's name 6 Plan Name 5a Total number of participants at the beginning of the plan year	Long Island Vitr	eoretinal Consultants	s, P.C.			
Great Neck NY 11021 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 3 Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. 5 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d PN 5c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 6d(1) Total number of active participants at the beginning of the plan year. 6d(2) Total number of active participants at the end of the plan year. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. 6aution: A penalty for the late or incomplete filling of this return/report	600 Northern Bly	d. Suite 216			2d Business	code (see instructions)
3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year	ooo northern Drv	u., 24100 210				
3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year	Great Neck	NY 110	21		621111	
3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year	3a Plan administrator's name	and address X Same as Plan Spo	onsor.		3b Administra	ator's EIN
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a 355 b Total number of participants at the beginning of the plan year					3c Administra	ator's telephone number
5a Total number of participants at the beginning of the plan year						
5a Total number of participants at the beginning of the plan year	The state of the s				4d PN	
b Total number of participants at the end of the plan year	C Plan Name					
b Total number of participants at the end of the plan year	5a Total number of participant	ts at the beginning of the plan year			5a	35
complete this item)					5b	42
d(1) Total number of active participants at the beginning of the plan year					5c	
d(2) Total number of active participants at the end of the plan year					5d(1)	34
Pumber of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 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 participants who terminated employment during the plan year with accrued benefits that were less 5e 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 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 Date Enter name of individual signing as employer or plan sponsor			And the second second second second			40
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 Date Enter name of individual signing as employer or plan sponsor Date Enter name of individual signing as employer or plan sponsor	e Number of participants wh	no terminated employment during th	e plan year with accrued be	enefits that were less	5e	r
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 employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor					use is established	
SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor Date Enter name of individual signing as employer or plan sponsor	Under penalties of perjury and of	other penalties set forth in the instru	ictions, I declare that I have	examined this return/re	eport, including, if	applicable, a Schedule
Signature of plan administrator Date Enter name of individual signing as plan administrator 7/25/19 APVIA M FASTENBERG Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor			as well as the electronic ve	rsion of this return repo	it, and to the best	of filly knowledge and
Signature of individual signing as plan administrator SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as plan administrator TASIL AULA M FHSTENBELG Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor		1. Weller	7/25/19	MICHAEC	- J. W	ILEY
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	Signature of plan	administrator				
Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor		tar 1	7/25/19	AAVIA A	1 FASTEN	BERG
	Signature of empl			Enter name of individ	dual signing as en	

Form 5500-SF (2018) Page **2**

	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)								
D	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.								
С	If the plan is a defined benefit plan, is it covered under the PBGC in	surance pi	ogram (see ERISA se	ction 4	021)?				
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC pr	emium filing for this pl	an yea	r		4133666. (See instructions.)	i	
Pa	rt III Financial Information							_	
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End of Year	_	
а	Total plan assets	7a		787,		` ,			
-	Total plan liabilities	7b		· · ·				_	
С	Net plan assets (subtract line 7b from line 7a)	7c	1,	787,	244		3,455,94	ł O	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t		(b) Total			
а	Contributions received or receivable from: (1) Employers	8a(1)		694,	466		·		
	(2) Participants	8a(2)							
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b		-25,	770				
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					1,668,69)6	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
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						0	
	Net income (loss) (subtract line 8h from line 8c)	8i					1,668,69)6	
j	Transfers to (from) the plan (see instructions)	8j							
Par	rt 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: 1C 3D								
b	If the plan provides welfare benefits, enter the applicable welfare for	eature code	es from the List of Plar	n Chara	cterist	ic Codes	in the instructions:		
Par	t V Compliance Questions								
10	During the plan year:				Yes	No	Amount		
а	Was there a failure to transmit to the plan any participant contributed described in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	duciary Correction	10a		Х			
b	Program) Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not i	nclude transactions	10a 10b		Х		_	
C					Х		700,00) ()	
	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused							_	
е	by fraud or dishonesty?								
f	Has the plan failed to provide any benefit when due under the plan?								
g									
h	1 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 exceptions to providing the notice applied under 29 CFR 2520.10	ne required	notice or one of the	10i					
			•			•			

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).

2018

OMB No. 1210-0110

This Form is Open to Public Inspection

	, ,	File as	an attachment to Form	5500 or	5500-SF.					
For calendar p	lan year 2018 or fiscal pla	n year beginning	01/01/2018		and endin	g	12/31/20	018		
Round off amounts to nearest dollar.										
Caution: A	penalty of \$1,000 will be a	assessed for late filing of	this report unless reasor	nable caus	se is established	d.				
	A Name of plan B Three-digit									
	land Vitreoretir Plan II	nal Consultants	, P.C. Cash Bal	Lance	plan num	ber (PN)	•	006		
Pelision	Pian II									
C Plan spanso	or's name as shown on line	22 of Form 5500 or 550	n eE		D Employer	Idontifica	ation Number (F	=INI)		
• Flair spoils	Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF D Employer Identification Number (EIN)									
Long Is	Long Island Vitreoretinal Consultants, P.C. 11-2566918									
E Type of plan:	X Single Multiple-A	A Multiple-B	F Prior year pla	an size: 🛚 🗵	100 or fewer	101-5	500 More th	nan 500		
Part I	Basic Information									
1 Enter the	valuation date:	Month01 Da	ay <u>01</u> Year	2018						
2 Assets:										
a Market	value					. 2a		1,786,924		
b Actuari	al value					2b		1,786,924		
3 Funding t	arget/participant count bre	akdown		(1) N	Number of	(2) Ves	ted Funding	(3) Total Funding		
				•	ticipants		Target	Target		
a For reti	red participants and benef	iciaries receiving paymer	nt		0		0	0		
b For ten	minated vested participant	s			1		580	580		
c For acti	ve participants				34		1,332,663			
d Total					35	1	1,333,243	1,333,243		
4 If the plan	n is in at-risk status, check	the box and complete lin	es (a) and (b)]					
a Funding	g target disregarding preso	cribed at-risk assumptions	s			4a				
	g target reflecting at-risk as	•								
	status for fewer than five o					4b				
5 Effective	interest rate					5	5.58%			
6 Target no	ormal cost					6		1,054,436		
•	Enrolled Actuary									
accordance wit	ny knowledge, the information supp h applicable law and regulations. In	my opinion, each other assumpt								
combination, of	fer my best estimate of anticipated	experience under the plan.								
SIGN		Ell								
HERE	X				_		07/24/201	19		
	Si	gnature of actuary					Date			
Jeffrey F. Hartmann, FSA, MSPA 1702699										
Type or print name of actuary Most recent enrollment number										
Kravitz, LLC 818-995-6100										
	Firm name Telephone number (including area code)									
16030 Vent	ura Blvd, Suite	200								
Encino	CA 91	436								
ETICTIO		Address of the firm			_					
If the actual to	a not fully reflected and	aulation or ruling process	rotod under the etetite !:	oomplet!	na thio cahaaliili	o obsol-	the hey and			
instructions	s not fully reflected any re	guiation or ruling promulg	gateu under the Statute If	Completi	ng mis schedule	e, check	ine dox and se			

Pac	e	2	-	

P	art II	Begir	ning of Year (Carryov	er and Prefunding Bal	ances						
							(a) C	arryover balanc	е	(b) P	refundi	ng balance
7	7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)									0		
8	8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)											0
9										0		
10	37											
11	Prior yea	ar's exces	s contributions to I	be added to	o prefunding balance:							
a Present value of excess contributions (line 38a from prior year)										440,829		
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of									24,907			
	b(2) Int	erest on l	ine 38b from prior	year Sche	dule SB, using prior year's ac	tual -						24,907
												0
	C Total a	ivailable a	t beginning of curre	nt plan yea	r to add to prefunding balance							465,736
	d Portio	n of (c) to	be added to prefu	inding bala	nce							0
12	Other red	ductions i	n balances due to	elections of	or deemed elections				0			0
13	Balance	at beginr	ning of current year	· (line 9 + li	ine 10 + line 11d – line 12)				0			0
F	Part III	Fun	ding Percenta	aes								
14	Fundina										14	134.02%
											15	134.02%
	Prior yea	ar's fundir	ng percentage for p	ourposes o	f determining whether carryo	ver/prefund	ding balance	s may be used	to reduce	current	16	121.24%
17					less than 70 percent of the fu						17	%
Р	art IV	Con	tributions and	l Liauidi	ity Shortfalls					·		
					ar by employer(s) and employ	rees:						
	(a) Date		(b) Amount pa		(c) Amount paid by	(a) D	Date	(b) Amount	paid by	(c) Amou	nt paid by
	(MM-DD-YYYY) employer(s) employees (MM-DD-YYYY) employer(s) employees											
	9/12/2			00,000	0							
	9/28/2 4/08/2			52,396 42,070	0							
0	4/00/2	019		12,070	0							
Totals ► 18(b) 1,694,466 1						6 18(c)		0				
19	Discount	ed emplo	ver contributions -	- SAA instri	uctions for small plan with a v	aluation da	` ,			- ()		
			-						19a			0
 a Contributions allocated toward unpaid minimum required contributions from prior years										0		
C Contributions allocated toward minimum required contribution for current year adjusted to valuation date									1,629,364			
20			itions and liquidity		Sa sommodion for current year	aajasiea ii	valuation u		.55			.,,501
_5			-		e prior year?						П	Yes X No
	b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?											
	C If line	20a is "Y	es," see instruction	ns and com	nplete the following table as a Liquidity shortfall as of end		of this plan:	/ear				
		(1) 1s	t		(2) 2nd	or quarter (rear 3rd		(4) 4th	<u> </u>

P	art V	Assumpti	ons Used to Determin	e Funding Target and Targ	get Normal Cost					
21	Discount	rate:								
	a Segm	1st segment: 2nd segment: 3rd segment: 3.92 % 5.52 % 6.29				ı	N/A, full yield curve used			
	b Applicable month (enter code)									
22	22 Weighted average retirement age 22									
23	23 Mortality table(s) (see instructions) Prior regulation: Prescribed - combined Prescribed - separate Substitute									
	Current regulation: X Prescribed - combined Prescribed - separate Substitute									
Pa	art VI	Miscellane		Ц		· ·	П			
24	Has a ch	ange been ma	ade in the non-prescribed act	uarial assumptions for the current p	lan year? If "Yes," see i	nstruction	s regarding required			
	attachme	nt					Yes 🛛 No			
25	Has a me	ethod change l	been made for the current pla	in year? If "Yes," see instructions r	egarding required attach	ment	Yes X No			
26	Is the pla	n required to բ	provide a Schedule of Active	Participants? If "Yes," see instruction	ons regarding required a	attachmen	t			
27		•	alternative funding rules, ent	er applicable code and see instructi	ons regarding	27				
P	art VII	Reconcili	ation of Unpaid Minim	um Required Contribution	s For Prior Years					
28	Unpaid n	ninimum requir	red contributions for all prior y	ears		28	0			
29				unpaid minimum required contribut		29	0			
30	Remainir	ng amount of u	inpaid minimum required con	tributions (line 28 minus line 29)		30	0			
Pá	art VIII	Minimum	Required Contributio	n For Current Year						
31			d excess assets (see instructi							
			,			31a	1,054,436			
-	b Excess	assets, if app	olicable, but not greater than I	ine 31a		31b	453,681			
32	Amortiza	tion installmen	nts:		Outstanding Bala	nce	Installment			
	a Net sh	ortfall amortiza	ation installment			0	0			
	b Waive	amortization	installment			0	0			
33				er the date of the ruling letter granti) and the waived amount		33				
34	Total fun	ding requireme	ent before reflecting carryove	r/prefunding balances (lines 31a - 3	31b + 32a + 32b - 33)	34	600,755			
				Carryover balance	Prefunding balar	nce	Total balance			
35	Balances	elected for us	se to offset funding	· · · · · · · · · · · · · · · · · · ·						
				0		0	0			
36	Additiona	l cash require	ment (line 34 minus line 35).			36	600,755			
37	37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)									
38	38 Present value of excess contributions for current year (see instructions)									
	a Total (excess, if any, of line 37 over line 36)									
	b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances									
39	Unpaid n	ninimum requii	red contribution for current ye	ar (excess, if any, of line 36 over lir	ne 37)	39	0			
40	Unpaid n	ninimum requi	red contributions for all years			40	0			
Pa	rt IX	Pension	Funding Relief Under	Pension Relief Act of 2010	(See Instructions	s)				
41	If an elec	ion was made	e to use PRA 2010 funding re	ief for this plan:						
	a Schedule elected									
	b Eligible plan year(s) for which the election in line 41a was made									

LONG ISLAND VITREORETINAL CONSULTANTS, P.C. CASH BALANCE PENSION PLAN II EIN 11-2566918 Plan Number 006

Schedule SB, Line 22 - Description of Weighted Average Retirement Age.

The assumed average retirement age is 63.

Participants are assumed to retire at the plan's Normal Retirement Age, or at the end of the current plan year if later.

LONG ISLAND VITREORETINAL CONSULTANTS, P.C. CASH BALANCE PENSION PLAN II EIN 11-2566918 Plan Number 006

Schedule SB, Part V -- Summary of Plan Provisions

Eff	fective Date	January 1, 2016 as amended through October 5, 2017.			
De	finitions				
-	Plan Year	January 1 through December 31.			
-	Compensation	Total compensation paid during Plan Year.			
-	Years of Service	Service for eligibility, benefits and vesting based upon entire period of service. The 1000 hours of service method is used in measuring this service.			
-	Accrued Pension	Actuarial equivalent of the balance of the Participant's Accumulation Account as of Valuation Date projected to his Normal Retirement Date.			
-	Actuarial Equivalence	Based on the interest rate of 3% and mortality in accordance with the 1994 Group Annuity Reserving table projected to 2002.			
-	Accumulation Account	Hypothetical account established for each participant. Each plan year, the account is credited with participant's hypothetical contribution in accordance with the plan. Account accumulates guaranteed earnings based on the interest rate of 3%.			

Hypothetical Contribution

equivalent to providing an annual annuity of 0.50% of annual compensation, beginning at normal retirement age.

For some participants, the contribution is the amount

Contribution formula varies by participant.

Contribution amounts this year range from 2.60% to 84.46% of expected compensation.

Eligibility Employees become eligible upon attainment of age 21

and completion of 1 year of service, and enter the plan on

the January 1 or July 1 following completion of the

eligibility requirements.

However, employees not listed in the Appendix of Eligible Employees are excluded from the Plan.

Normal Retirement

- Age The later of age 62 and the fifth anniversary of the

Participant's entry date (in the prior CB plan).

- Annual Pension The participant's Accrued Benefit determined as of his

Normal Retirement Date based on the actuarial equivalent value of the Accumulation Account.

- Payment of Pensions Straight life annuity for single employees. Reduced Joint

and 100% Survivor annuity for married employees. Optional forms of benefits include single sum and

annuities.

Early Retirement Benefit Same as Severance Benefit.

Late Retirement Benefit Actuarial equivalent of the Accumulation Account as of

the participant's late retirement date.

Disability Benefit Actuarial equivalent value of vested accrued pension.

Severance Benefit Accrued Benefit times Vested Percentage. The Vested

Percentage is based on Years of Service as follows:

Years of Service	Vested Percentage
0 years	0%
1 years	0%
2 years	0%
3 years or more	100%

Death Benefit Before Retirement

- Active Participants Actuarial equivalent value of vested accrued pension.

Former Participants 100% of the value of the vested deferred pension.

Top-Heavy Provisions

- Minimum Benefit For employees also participating in the Long Island

Vitreoretinal Consultants, P.C. 401(k) Employee Savings Plan, contribution of 5% of total compensation to be

provided under that plan.

- Minimum Vesting 100% after 3 years of service.

Voluntary Contributions Not Permitted

Rollover Contributions Not Permitted

Loans to Participants Not Permitted