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

2018

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information							
For calenda	ar plan year 2018 or fi	iscal plan year beginning 01/01/2	018	and ending 12	2/31/2018				
A This ret	turn/report is for:	x a single-employer plan		olan (not multiemployer) (mployer information in ac	_				
		a one-participant plan	a foreign plan						
B This retu	urn/report is	the first return/report	the final return/report						
		an amended return/report	a short plan year retu	rn/report (less than 12 m	onths)				
C Check	box if filing under:	X Form 5558	automatic extension		DFVC progra	am			
		special extension (enter descr	iption)						
Part II	Basic Plan Info	ormation—enter all requested inf	formation						
1a Name ROBERT H.	of plan OZER DMD PC 401(K) PLAN			1b Three-dig plan num (PN) ▶				
					1c Effective	date of plan 01/01/2015			
		oyer, if for a single-employer plan) om, apt., suite no. and street, or P.O) Roy)			Identification Number			
		ce, country, and ZIP or foreign posta		tructions)	(EIN)	13-2784019			
ROBERT H.	OZER DMD PC					s telephone number 18-761-1800			
					2d Business	code (see instructions)			
	IOND AVENUE .AND, NY 10314				621210				
3a Plan administrator's name and address ∑ Same as Plan Sponsor.					3b Administra	ator's EIN			
					3c Administra	ator's telephone number			
					7 (4111111111111111111111111111111111111	a.e. 6 10.0p.101.0 11a.1126.			
4 17.11					41				
		e plan sponsor or the plan name ha onsor's name, EIN, the plan name a			4b EIN				
•	or's name				4d PN				
C Plan N	lame								
5a Total i	number of participants	s at the beginning of the plan year			5a	7			
_		s at the end of the plan year			5b	7			
		account balances as of the end of		·	5c	7			
'	,	articipants at the beginning of the pla			5d(1)	7			
		articipants at the end of the plan yea			5d(2)	7			
Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested					5e	0			
Caution: A	A penalty for the late	or incomplete filing of this return	n/report will be assessed	d unless reasonable cau	use is establish	ed.			
SB or Sche		ther penalties set forth in the instructed and signed by an enrolled actuary, a splete.							
0.0				ROBERT H. OZER	:R				
HERE	Signature of plan a	administrator	Date	Enter name of individ	ual signing as pl	an administrator			
SIGN	Filed with authorized	d/valid electronic signature.	10/04/2019	ROBERT H. OZER					
HERE	Signature of emplo	oyer/plan sponsor	Date	Enter name of individ	ual signing as er	nployer or plan sponsor			

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b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (ICPA) under 20 For 2520.104-476 (See instructions on waiver eligibility and conditions.)		Were all of the plan's assets during the plan year invested in eligib		,					. X Yes	No
Part III Financial Information (See instruction Part III Financial Information (a) Beginning of Year (b) End of Year (b) End of Year (c) End of Year (c) End of Year (d) Beginning of Year (d) End of Year (e) End of Year		under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)								No
7 Plan Ássets and Liabilities							_		_	
a Total plan assets	Par	t III Financial Information								
b Total plan isabilities	7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) En	d of Year	
C Net plan assets (subtract line 7b from line 7a) 7c 170192 217179 8 Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total a Contributions received or receivable from: (1) Employers 8a(1) 12304 (2) Participants	а	Total plan assets	7a	1	70192				217179	
8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers	b	Total plan liabilities	7b							
a Contributions received or receivable from: (1) Employers. (2) Participants. (3) Others (including rollovers). (3) Others (including rollovers). (4) Employers. (5) Others (including rollovers). (6) Other income (loss). (7) Other income (loss). (8) Others (including rollovers). (8) Bb15637 (8) C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b). (8) Experiments (loss). (8) Bb15637 (9) Other income (loss). (1) Benefits paid (including direct rollovers and insurance premiums to provide benefits). (8) G Benefits paid (including direct rollovers and insurance premiums to provide benefits). (9) Certain deemed and/or corrective distributions (see instructions). (8) Bc. (1) Contracteristrics (salaries, fees, commissions). (8) Bg. (1) Other expenses. (2) G Administrative service providers (salaries, fees, commissions). (8) Bg. (1) Transfers to (from) the plan (see instructions). (8) Bg. (1) Transfers to (from) the plan (see instructions). (8) Bh. (1) Net income (loss) (subtract line 8h from line 8c). (8) Bh. (1) Part IV Plan Characteristics (1) Part IV Plan Characteristics. (2) Bar (1) Part Characteristics (3) If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: (2) Az 2E 2F 2G 2J 2T 3D. (3) British plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: (2) Part V Compliance Questions (3) During the plan year: (4) 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). (4) Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud of dishonesty? (5) C was the plan covered by a fidelity bond? (6) Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud of dishonesty? (7) C on other organization that prov	С	Net plan assets (subtract line 7b from line 7a)	7с	1	70192				217179	
(2) Participants	8	Income, Expenses, and Transfers for this Plan Year		(a) Amour	nt			(b)	Total	
(3) Others (including rollovers)			8a(1)		12304					
b Other income (loss)		(2) Participants	8a(2)	,	50320					
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		(3) Others (including rollovers)	8a(3)							
d Benefits paid (including direct rollovers and insurance premiums to provide benefits). 8d	b	Other income (loss)	8b	-	15637					
to provide benefits)			8c						46987	
f Administrative service providers (salaries, fees, commissions)		. , .	8d							
g Other expenses	е	Certain deemed and/or corrective distributions (see instructions)	8e							
Total expenses (add lines 8d, 8e, 8f, and 8g)	f	Administrative service providers (salaries, fees, commissions)	8f			\rightarrow				
i Net income (loss) (subtract line 8h from line 8c)	g	Other expenses	8g			_				
Transfers to (from) the plan (see instructions)	h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							
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: 2A 2E 2F 2G 2J 2T 3D b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: Part V Compliance Questions 10 During the plan year: 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) b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) c Was the plan covered by a fidelity bond? d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? 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 10f X 9 Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) 10g X 11f this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) 10h X			8i						46987	
If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: Part V	j	Transfers to (from) the plan (see instructions)	8j							
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Part V Compliance Questions 10 During the plan year: 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)	9a 		feature co	odes from the List of Pl	an Cha	racteri	istic Co	odes in the in	structions:	
10 During the plan year: 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)	b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acteris	tic Co	des in the ins	tructions:	
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)	Part	t V Compliance Questions								
described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10	During the plan year:				Yes	No		Amount	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	а	described in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	iduciary Correction	10a		X			
C Was the plan covered by a fidelity bond? 100 X 10000 d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? 100 X e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) 10e X f Has the plan failed to provide any benefit when due under the plan? 10f X g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) 10g X h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) 10h X i If 10h was answered "Yes," check the box if you either provided the required notice or one of the	b	Were there any nonexempt transactions with any party-in-interest	? (Do not	include transactions						
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? 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.) f Has the plan failed to provide any benefit when due under the plan? g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) 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	С				10c	X			1000	0
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.)	d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused					X		1000	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under					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	f	Has the plan failed to provide any benefit when due under the plan	n?		10f		X			
2520.101-3.) If 10h was answered "Yes," check the box if you either provided the required notice or one of the	g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		X			
	h				10h		X			
exceptions to providing the notice applied under 29 CFR 2520.101-3	i				10i					

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Part	VI Pension Funding Compliance						
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete (Form 5500) and line 11a below)			Yes 🛚 No			
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a					
12	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	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						
lf y	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.						
b	Enter the minimum required contribution for this plan year	12b					
С	Enter the amount contributed by the employer to the plan for this plan year	12c					
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left 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?		Ye	s 🔀 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 control of the PBGC?	the		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 which assets or liabilities were transferred. (See instructions.)	n(s) to					
1	3c(1) Name of plan(s):	(2) EIN(s))	13c(3) PN(s)			

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Banefit Security Administration

Pension Banefit 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 section 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

For calendar plan year 2016 or fiscal plan year beginning 0.1/01/2018 and andring 12/31/2018 A This return/report is for a single-employer plan an ambiline-employer plan for multisumployer) (Filter achesing this bex must attach a list of participating employer information in accordance with the form instructions.) a foreign plan in the first return/report is an amended return/report in a short plan year return/report (less than 12 months). C Check box if filing under: Per 9558 and automatic extension DFVC program special extension (enter description) PERCIFIE Basic Plan Information — enter all requested information. 1a Name of plan Robert H. Ozer DMD PC 401 (k) Plan 1b Three-digit plan number (PN) — 00.1 1c Effective date of plan Robert H. Ozer DMD PC 401 (k) Plan 1c Plan sponsor's name (employer, if for a single-employer plan) Mailing Address (include room, apt., sulte no. and sinest, or P.D. Box) City or from, static or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2a Plan sponsor's name (employer, if for a single-employer plan) Address (include room, apt., sulte no. and sinest, or P.D. Box) City or from, static or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2b Employer Identification Number (PN) — 1800 R1chmond Avenue 7y	P	artill Annual Report	t Identification Information				
A This return/report is for: a isst of participating employer information in accordance with the form instructions.) a foreign plan in a foreign plan in a foreign plan in a meneded return/report is a short plan year return/report (less than 12 months) C Check box if filing under: Form 5558	For	calendar plan year 2018 or f	iscal plan year beginning	01/01/2018	and ending	12/31/20:	L8
This return/report is:	A	This return/report is for:		a list of participating			
an amended return/report a short plan year return/report (less than 12 months) C Check box if filing under: Form 5558 automatic extension DFVC program	B	This return/report is:					
C Check box if filing under:	H		님	a short plan year retr	rn/report (less than 12	months)	
Special extension (enter description) Partill Basic Plan Information			an amended returns port		miniport flood man 12		
Part	C	Check box if filing under:	=			DFVC p	rogram
18 Name of plan Robert H. Ozer DMD PC 401 (k) Plan 10 Cffective date of plan 0.1/2015 2a Plan sponsor's name (emotoyer, if for a single-employer plan) Maling Address (include norm, sph. suite nor and street, or PO Box) City of rown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Robert H. Ozer DMD PC 1800 Richmond Avenue 19 States Zaland PY 10314 3a Plan administrator's name and address XI 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. 3 Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Plan Name of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Plan number of participants at the beginning of the plan year C Plan number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Plan number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants at the beginning of the plan year C Number of participants who terminated employment during the plan year Number of participants who terminated employment during the plan year Number of participants who terminated employment during the plan year Number of participants who terminated employment during the plan year Number of participants who terminated employment during the plan year Number of participants who terminated employment during the plan year Number of participants who terminated employment during	in.	Pacio Plan Inf					
Robert H. Ozer DMD PC 401 (k) Plan Plan sponsor's name (employer, if for a single-employer plan) 1c Effective date of plan 0,101,201 5 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number (City of town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2b Employer Identification Number (EIN) 13-2784019 2c Sponsor's telephone number (71,8) 751-1800 2d Business code (see instructions) 621210 2d Business code (see instructions) 621210 3a Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number (11,8) 761-1800 3c Administrator's name and address X Same as Plan Sponsor 3b Administrator's telephone number (11,8) 1c Administrator's name (11,8) 1c Administrator's telephone number (11	_		Difficultion enter an requested	intermation		1b Three-digit	
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 fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Robert N. Ozer DND PC 1800 Richmond Avenue 1800 Richmond Avenue 1805 Staten Island NY 10314 3a Plan administrator's name and address. IX Same as Plan Sponsor 3b Administrator's relephone number (21210) 3c Administrator's telephone number (21210) 3c Administrator's telephone number (21210) 4b EIN 4d PN 4d PN 4d PN 4d PN 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 at the end of the plan year 6d(1) Total number of active participants at the beginning of the plan year 6d(1) Total number of participants at the end of the plan year 8d(1) Total number of participants at the end of the plan year 6d(1) Total number of participants at the end of the plan year 8d(1) Total number of participants at the end of the plan year 9d(1) Total number of participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(2) Total number of participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(2) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end of the plan year 1d(3) Total number of active participants at the end o		•	PC 401 (k) Plan			plan numb	er
A Plan sponsor's name (employer, if for a single-employer plan) Mailing Address (include room, apr., suite no and street, or P.O. Box) City or frown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Robert H. Ozer DMD PC 1800 Richmond Avenue 180 Richmond Avenue 180 Richmond Avenue 181 States zsland NY 10314 3a Plan administrator's name and address [X] 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. 2 Sponsor'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 5b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 5c 7 d(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 active participants at the end of the plan year 6d(2) Total number of active participants at the end of the plan year 6d(2) Total number of active participants at the end of the plan year 6d(2) Total number of active participants at the end of the plan year 6d(2) Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 6c 7 5d(2) 7 5d(2) 7 5d(2) 7 5e 0 6caution: A penalty for the late or incomplete filling of this return/report, will be assessed unless reasonable causes as established. 7cobert H. Ozer 8cieve H. Ozer							1 11-
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) Robert H. Ozer DND PC 1800 Richmond Avenue 18							,
Robert H. Ozer DND PC 1800 Richmond Avenue 35 Staten Island RY 10314 36 Plan administrator's name and address IX Same as Plan Sponsor 37 Administrator's EIN 38 Administrator's EIN 39 Administrator's EIN 30 Administrator's EIN 30 Administrator's EIN 40 EIN 41 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 4 PN 4 PN 5 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) 4 CONTRACT Of active participants at the beginning of the plan year 5 CONTRACT Of active participants at the beginning of the plan year 6 Plan Name 5 CONTRACT Of active participants at the beginning of the plan year (only defined contribution plans complete this item) 6 CONTRACT Of active participants at the beginning of the plan year 6 Plan Namber of active participants at the beginning of the plan year 7 Sod(1) 7 8 Contract Of Participants of the plan year (only defined contribution plans complete this item) 8 CONTRACT Of active participants at the beginning of the plan year 9 Number of participants who terminated employment during the plan year with accurate benefits that were essentially accurate the plan year of participants of perity and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule as the electronic version of this return/report, including, if applicable, a Schedule as the electronic version of this return/report, and to the best of my knowledge and belief, its true, parted, and complete. 8 Contract H. Ozer	2a	Mailing Address (include ro	om, apt., suite no. and street, or P.	O. Box)	structions)		
2d Business code (see instructions) 621210 2d Business code (see instructions) 621210 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. a Sponsor's name C Plan Name 5a 7 b Total number of participants at the beginning of the plan year 5b 7 b Total number of participants at the ond of the plan year 5c 7 b Total number of participants at the end of the plan year 5c 7 b Total number of participants at the beginning of the plan year 7 c Number of participants at the beginning of the plan year 9 d(1) Total number of active participants at the beginning of the plan year 9 Number of participants who terminated employment during the plan year with accured benefits that were elses than 100% vested 5e 0 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjuy and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule as the electronic version of this return/report, and to the best of my knowledge and belief its true, carrect, and complete. Sign Robert B. Ozer Robert B. Ozer					,	'	
1800 Richmond Avenue US States Island MY 10314 3a Plan administrator's name and address [X] 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. 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 f Number 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 belief It is true, perrect, and complete. Robert H. Ozer Robert H. Ozer							
3b Administrator's name and address IX Same as Plan Sponsor 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 4d PN 5a 7 5b 7 Total number of participants at the beginning of the plan year		1800 Richmond Aven	ue				,
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						75. 44	4 FINI
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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. Sponsor's name C Plan Name 4d PN 5a 7 b Total number of participants at the beginning of the plan year							
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a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year	4					4b EIN	
5a Total number of participants at the beginning of the plan year	2		Also s hame, Elly, the plan hatte	and the plan homeon work	in that retains appears	4d PN	
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complete this item) d(1) Total number of active participants at the beginning of the plan year d(2) Total number of active participants at the end of the plan year Number of participants who terminated employment during the plan year with accrued benefits that were Number of participants who terminated employment during the plan year with accrued benefits that were Se 0 Caution: A penalty for the late or incomplete filling 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 as the electronic version of this return/report, and to the best of my knowledge and belief it is true, correct, and complete. Robert H. Ozer Sign Robert H. Ozer Robert H. Ozer							7
d(1) Total number of active participants at the beginning of the plan year d(2) Total number of active participants at the end of the plan year Number of participants who terminated employment during the plan year with accrued benefits that were Number of participants who terminated employment during the plan year with accrued benefits that were Secondary for the late or incomplete filling 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 a street of the late of the plan year Sign Robert H. Ozer Enter name of individual signing as plan administrator Robert H. Ozer	С					5c	7
Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	d(, g a a 4, q q, man p double de act d'été de act de dé dé dé dé dé dé de de act de la constitue de de de de de	. 5d(1)	7
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 as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. Sign Robert H. Ozer Sign Robert H. Ozer Robert H. Ozer	d(*******************	. 5d(2)	7
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 as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN Robert H. Ozer Enter name of individual signing as plan administrator Robert H. Ozer	е		terminated employment during the	e plan year with accrued be	nefits that were	. 5e	0
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 as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN Robert H. Ozer Enter name of individual signing as plan administrator Robert H. Ozer	Ca	ution: A penalty for the late	e or incomplete filing of this retu	rn/report will be assesse	d uniess reasonable d	ause is establishe	ed.
HERE Signature of plan administrator SIGN Robert H. Ozer	Un	der penalties of perjury and or Schedule MB completed	other penalties set forth in the instru and signed by	uctions, I declare that I hav	e examined this return	report, including, if	applicable, a Schedule
HERE Signature of plan administrator SIGN Robert H. Ozer	e	IGN Fue TEST	LIFE HE	RE	Robert H. Ozer		
SIGN Robert H. Ozer	100 years	Author .	ministrator	Pate 10 4 19	Enter name of individ	uat signing as plan	administrator
SIGN	1550	1 2 246	S	GN			
		UN	er/pran sponso	atele wia			oyer or plan sponsor

_				-
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6a Were all of the plan's ass	ets during the plan year invested in eligible	a assets? (Se	e instructions)				************	Wyo Die
	r of the annual examination and report of a						**************	XYes No
under 29 CFR 2520.104-4	16? (See instructions on waiver eligibility a	nd conditions	i.)				******	XYes No
	either line 6a or line 6b, the plan canno							
C If the plan is a defined be	nefit plan, is it covered under the PBGC in	surance prog	ram (see ERISA sec	tion 4	021)?	******	. Yes	☐ No ☐ Not determine
If "Yes" is checked, enter	the My PAA confirmation number from the	PBGC prem	ium filing for this yea	ar				(See instructions.)
Pari III Financial Info	ormation			_	_			
7 Plan Assets and Liabilities		in the	(a) Beginning	of Ye	ar	T	(b) End of Year
a Total plan assets	***************************************	7a		170,	192			217,179
	***************************************	7b						221,273
C Net plan assets (subtract	line 7b from line 7a)	7c		170,	192	1		217,179
	ransfers for this Plan Year		(a) Amou					(b) Total
a Contributions received or		18.			10 E	100		A second state of the
	***************************************	8a(1)		12,				
	***************************************	8a(2)		50,:	320	_		
	vers)	8a(3)						
	***************************************	8b	(:	15,6	37)			
d Benefits paid (including di	a(1), 8a(2), 8a(3), and 8b)rect rollovers and insurance premiums	8c		·············				46,987
to provide benefits)	ect rollovers and insurance premiums	8d						
	rrective distributions (see instructions)	8e			_		7	
	viders (salaries, fees, commissions)	8f	- Walley		_	100	20 13 10	
7.00	***************************************	8g		-				
the state of the s	8d, 8e, 8f, and 8g)	8h					100	
	t line 8h from line 8c)	81	100000				_	46,987
	n (see instructions)	8]				1000	A 5 TO 1 TO 1	40,367
Part IV Plan Charact		9				(See all		
	π benefits, enter the applicable pension fe	sture ender f	in the List of Disc.	Oh	_A? _ A		1	
2A 2E 2F 2G		ature codes i	ioni the List of Plan	Criara	ciensi	ic co	oes in the ii	nstructions;
b If the plan provides welfare	benefits, enter the applicable welfare fea	tura codas fre	om the List of Plan C	basasi	orietia	Cod	an in the inc	-tt
The plant provides Welland	beautiful and the applicable reliate lea	tare codes in	An the List of Flant C	ilai aci	er istic	Cour	ss in the ins	structions:
Part V Compliance C	Vuestions		-020 000		_	-		
10 During the plan year:	(destions			_			Toront	
	nsmit to the plan any participant contributi	one within the	time period	1	Yes	NO	NIA	Amount
	0.3-102? (See instructions and DOL's Vol			1				
				10a		x		
	pt transactions with any party-in-interest?			100				
				10b		х		
C Was the plan covered by	a fidelity bond?			10c	х		100	10,000
d Did the plan have a loss, by fraud or dishonesty?	whether or not reimbursed by the plan's fi			10d		х		
e Were any fees or commis	ssions paid to any brokers, agents, or othe	er persons by	an insurance				187	25 to Chit
e vveie any lees of commis		or all of the l	penefits under	1			State .	
carrier, insurance service	r, or other organization that provides some					X	40°C 173	
carrier, insurance service the plan? (See instruction	15.)	***************		10e			10000	
carrier, insurance service the plan? (See instruction f Has the plan failed to pro	vide any benefit when due under the plan	······································	***************************************	10f		х		
carrier, insurance service the plan? (See instruction f Has the plan failed to pro g Did the plan have any pa	vide any benefit when due under the planticipant loans? (If "Yes," enter amount as	of year end.)	***************************************	-		x		
carrier, insurance service the plan? (See instruction f Has the plan failed to pro g Did the plan have any pa h If this is an individual acc	vide any benefit when due under the plan	of year end.)	ns and 29 CFR	10f				
carrier, insurance service the plan? (See instruction f Has the plan failed to program Did the plan have any path if this is an individual acception 2520.101-3.)	vide any benefit when due under the plan rticipant loans? (If "Yes," enter amount as ount plan, was there a blackout period? (S	of year end.)	ns and 29 CFR	10f 10g		x		

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Change of						
Par	Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete S (Form 5500 and line 11a below)	chedule	SB	☐ Ye	s X	No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a				
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or sec ERISA?	tion 302	of	☐ Ye	s X	No
_	(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, a granting the waiver	and ente Da		of the le	tter rulir	ng
If y	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.					
b	Enter the minimum required contribution for this plan year.	12b				124,65
С	Enter the amount contributed by the employer to the plan for the plan year	12c				(Ris)
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				
Pan	VII Plan Terminations and Transfers of Assets					
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes	X N	lo	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a	20 (0 1)	26/		
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	e	☐ Y	es X	No	
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)	(s) to				
13	c(1) Name of plan(s): 13c(2) E	IN(s)		13c(3)	PN(s)	
						_