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		Identification Information	1							
For calend	lar plan year 2018 or fis	scal plan year beginning 01/01/2	2018	and ending 1	2/31/2018					
A This re	a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)									
		a one-participant plan	a foreign plan							
b This ret	urn/report is	the first return/report an amended return/report	the final return/report							
		urn/report (less than 12 m	ionths)							
C Check	box if filing under:	Form 5558	automatic extension		DFVC prog	ram				
		special extension (enter desc	• /							
Part II	Basic Plan Info	rmation—enter all requested in	formation							
1a Name BROOKLYN	of plan I WOMEN'S HEALTH	CARE, MD'S, P.C.			1b Three-di plan nun (PN) ▶	•				
					1c Effective	e date of plan 01/01/2017				
		yer, if for a single-employer plan)			2b Employe	er Identification Number				
		m, apt., suite no. and street, or P.0 e, country, and ZIP or foreign pos		structions)	(EIN)	11-2235754				
-	WOMENS HEALTH C		an oodo (ii rereign, ooo iii	sir deliene)		r's telephone number 718-852-5810				
					2d Business	s code (see instructions)				
110 4TH AV					621111					
BROOKLYN	I, INT 11217									
3a Plan a	administrator's name ar	nd address 🏻 Same as Plan Spo	nsor.		3b Administ	rator's EIN				
					3c Administ	trator's telephone number				
					, tarrillion	rater o terepriorio namber				
4 16.0					41					
		e plan sponsor or the plan name h nsor's name, EIN, the plan name a			4b EIN					
a Spons	sor's name				4d PN					
C Plan N	Name									
5a Total	number of participants	at the beginning of the plan year.			5a 1					
b Total	number of participants	at the end of the plan year			5b	1				
C Numb	per of participants with	account balances as of the end of	the plan year (only define	ed contribution plans	5c	1				
d(1) Tot	al number of active pa	rticipants at the beginning of the p	lan year		5d(1)	1				
d(2) Total number of active participants at the end of the plan year						1				
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 retur	n/report will be assesse	d unless reasonable ca						
SB or Scho		her penalties set forth in the instrund signed by an enrolled actuary, oblete.								
SIGN		/valid electronic signature.	10/14/2019	JOHN MAHER M.D.	HER M.D.					
HERE	Signature of plan a	dministrator	Date	Enter name of individ	Enter name of individual signing as plan administrator					
SIGN										
HERE	Signature of employer/plan sponsor Date Enter name of individ					vidual signing as employer or plan sponsor				

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6a b	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 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.)							
С	If you answered "No" to either line 6a or line 6b, the plan cann 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	orogram (see ERISA se	ection 4	021)?	[Yes No	Not determined . (See instructions.)
Pa	rt III Financial Information		_					
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End	of Year
<u>a</u>	Total plan assets	7a	:	24000				22081
b	Total plan liabilities	7b						
<u>c</u>	Net plan assets (subtract line 7b from line 7a)	7c	1	24000				22081
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b) ⁻	Total
a	Contributions received or receivable from: (1) Employers	8a(1)		0				
	(2) Participants	8a(2)		0				
	(3) Others (including rollovers)	8a(3)						
b	Other income (loss)	8b		-1919				
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						-1919
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d						
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	8e						
f	Administrative service providers (salaries, fees, commissions)	8f			_			
g	Other expenses	8g						
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						0
<u></u>	Net income (loss) (subtract line 8h from line 8c)	8i						-1919
	Transfers to (from) the plan (see instructions)	8j						
	t IV Plan Characteristics							
9a 	If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 2K 2F 2G 3D	feature co	odes from the List of Plant	an Cha	racteri	stic Co	odes in the ins	tructions:
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	des from the List of Pla	n Chara	acteris	tic 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	Fiduciary Correction	10a		X		
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	t? (Do not	include transactions	10b		Х		
c	Was the plan covered by a fidelity bond?			10c		X		
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bo	nd, that was caused	10d		X		
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 the plan? (See instructions.)					Х		
f	f Has the plan failed to provide any benefit when due under the plan?							
9	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)					X		
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)	•		10h		X		
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				

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Part	VI Pension Funding Compliance								
11	11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below)								
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 section ERISA?		:	Y	es X No				
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)								
a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver									
lf :	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)	PN(s)				

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.

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.

1210-0089

OMB Nos. 1210-0110

2018

This Form is Open to **Public Inspection**

Part I Annual Report	: Identification Information	1						
For calendar plan year 2018 or f	iscal plan year beginning	01/01/2018	and ending		/2018			
A This return/report is for: a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach list of participating employer information in accordance with the form instructions.)								
	a one-participant plan	a foreign plan						
B This return/report is								
	an amended return/report	a short plan year return	report (less than 12 m	ionths)	onths)			
C Check box if filing under:	X Form 5558	automatic extension		DFVC pro	gram			
	special extension (enter desc	cription)						
Part II Basic Plan Info	ormation—enter all requested in	nformation		10				
1a Name of plan	Health Care, MD's, 1	P.C.		1b Three- plan no	umber			
				(PN)	ve date of plan			
					1/2017			
2a Plan sponsor's name (emple	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.	O Boy)			yer Identification Number			
City or town, state or provin-	ce, country, and ZIP or foreign pos	stal code (if foreign, see instru	ictions)	(EIN) 11 - 2235754 2c Sponsor's telephone number				
Brooklyn Womens	Health Care, MDs, P.	C.		718-	852-5810			
110 4th Avenue				2d Busine	ess code (see instructions)			
Brooklyn	NY 112	217			621111			
3a Plan administrator's name a	and address 🗓 Same as Plan Sp	onsor.		3b Admin	3b Administrator's EIN			
					3c Administrator's telephone number			
*								
4 If the name and/or EIN of the	ne plan sponsor or the plan name	has changed since the last re	turn/report filed for	4b EIN				
this plan, enter the plan spi a Sponsor's name	onsor's name, EIN, the plan name	and the plan number from th	e last return/report.	4d PN				
c Plan Name								
				5a	1			
	s at the beginning of the plan year			5b				
b Total number of participantc Number of participants with	s at the end of the plan year n account balances as of the end o	of the plan year (only defined	contribution plans	5c	1			
complete this item)	•••••		*****************************	F-1/4)	1			
	articipants at the beginning of the			F.1(0)				
d(2) Total number of active p	articipants at the end of the plan y o terminated employment during t	earear with accrued be	nefits that were less	5e				
Aller and A O O O O A secretoral			*************************		Ushed.			
	or incomplete filing of this retu other penalties set forth in the instr							
SB or Schedule MB completed belief, it is true, corriect, and cor	and signed by an enrolled actuary	, as well as the electronic ver	sion of this return ope	nt, and to the	best of my knowledge and			
SIGN AAA	XIIV	10/14/19	John Maher M.					
HERE Signature of plan	administrator	Date /	Enter name of indivi	dual signing a	s plan administrator			
SIGN			100 E (100 E)	Ranks har osssument over				
HERE Signature of emp	loyer/plan sponsor	Date	Enter name of indivi	dual signing a	s employer or plan sponsor Form 5500-SF (2018)			

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	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)								es No
С	If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year								etermined structions.)
Pa	t III Financial Information								
7	Plan Assets and Liabilities (a) Beginning of Year (b) End								
a	Total plan assets	7a		24,	000				22,081
<u>b</u>	Total plan liabilities	7b							
C	Net plan assets (subtract line 7b from line 7a)	7c		24,	000				22,081
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b)	Total	
a	Contributions received or receivable from: (1) Employers	8a(1)			0				
	(2) Participants	8a(2)			0				
	(3) Others (including rollovers)	8a(3)							
<u>b</u>	Other income (loss)	8b		-1,	919				
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							-1,919
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								
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							С
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)								-1,919
	Transfers to (from) the plan (see instructions)	8j							
Pai	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 2K 2F 2G 3D	feature co	odes from the List of Pla	an Chai	racteris	stic Co	des in the ins	tructions:	
b	If the plan provides welfare benefits, enter the applicable welfare f	eature cod	les from the List of Pla	n Chara	cterist	ic Cod	les 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 contributed described in 29 CFR 2510.3-102? (See instructions and DOL's N	oluntary F	iduciary Correction	10a		Х			
b	Program)	t? (Do not	include transactions	10b		Х			
c				10c		Х			
d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?					Х			
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 the plan? (See instructions.).					Х			
_ f	f Has the plan failed to provide any benefit when due under the plan?					Х			
g	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)					Х			
h	h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)					Х			
i	If 10h was answered "Yes," check the box if you either provided to exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	10i					

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Part	VI P	ension Funding Compliance						
11		a defined benefit plan subject to minimum funding requirements? (If "Yes," se 5500) and line 11a below)		d complete Sch	edule S	В	_ Y	es 🗌 No
11a	Enter th	he unpaid minimum required contributions for all years from Schedule SB (Fo	orm 5500) line 40		11a			
12	ERISA?	a defined contribution plan subject to the minimum funding requirements of services.			n 302 of		Y	es 🛛 No
		s," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)						
a		ver of the minimum funding standard for a prior year is being amortized in this g the waiver.					the letter Year _	ruling
lf	you com	npleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500)	, and skip to lir	ie 13.				
b	Enter the	e minimum required contribution for this plan year			12b			
С	Enter the	e amount contributed by the employer to the plan for this plan year			12c			
d		ct the amount in line 12c from the amount in line 12b. Enter the result (enter a mount)			12d			
е	Will the	minimum funding amount reported on line 12d be met by the funding deadling	ne?			Yes	No	N/A
Part	VII P	Ian Terminations and Transfers of Assets						
13a	Has a re	esolution 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		all the plan assets distributed to participants or beneficiaries, transferred to an of the PBGC?					Yes X	No
С		ng this plan year, any assets or liabilities were transferred from this plan to an assets or liabilities were transferred.	other plan(s), ide	entify the plan(s)	to			

13c(2) EIN(s)

13c(3) PN(s)

13c(1) Name of plan(s):