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		t Identification Information								
For calend	dar plan year 2018 or t	fiscal plan year beginning 01/01/2	2018		and ending 12	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		oreign plan				,		
B This ref	turn/report is	the first return/report	the	final return/report						
		an amended return/report	a sl	hort plan year return	/report (less than 12 m	onths)				
C Check	box if filing under:	X Form 5558	au	tomatic extension		DFVC	program			
		special extension (enter desc	. ,							
Part II	Basic Plan Info	ormation—enter all requested in	nformatio	n						
1a Name						1b Th	ree-digit			
B & G MED	ICAL MANAGEMENT	, INC. PROFIT SHARING PLAN					n number N) ▶	002		
							ective date o	L.		
								1/2000		
		oyer, if for a single-employer plan) om, apt., suite no. and street, or P.C	O. Box)			2b Em (EI	-	fication Number 086308		
		ice, country, and ZIP or foreign post		(if foreign, see instru	uctions)		,			
B & G MED	ICAL MANAGEMENT	, INC.				2C Sp	onsor's telep 845-354	hone number 4-2444		
						2d Bus	siness code ((see instructions)		
188 SOUTH NEW CITY,	H MAIN STREET NY 10956						6211	11		
11211 0111,	141 10000									
3a Plan a	administrator's name a	and address X Same as Plan Spo	nsor.			3b Administrator's EIN				
		_				2		 		
						3C Adı	ministrator's	telephone number		
		ne plan sponsor or the plan name honsor's name, EIN, the plan name a				4b EIN				
	sor's name	onsor's name, Lin, the plan name of	and the p	pian number nom un	e last return/report.	4d PN				
C Plan I										
5a Total	number of participant	s at the beginning of the plan year.				5a		10		
		s at the end of the plan year				5b		10		
		account balances as of the end of				5c		10		
d(1) To	tal number of active pa	articipants at the beginning of the p	olan year			5d(1)		4		
d(2) To	tal number of active p	articipants at the end of the plan ye	ear			5d(2)		4		
than	100% vested	o terminated employment during the				5e		0		
		or incomplete filing of this retur								
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		d/valid electronic signature.		10/14/2019	MARC PRICE					
HERE	Signature of plan	administrator		Date	Enter name of individ	ual signin	g as plan adr	ministrator		
SIGN										
HERE	Signature of empl	loyer/plan sponsor		Date	Enter name of individ	ual signin	g as employe	er or plan sponsor		

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6a	6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)								
b	Are you claiming a waiver of the annual examination and report of a under 29 CFR 2520 104-462 (See instructions on waiver eligibility)							X Yes □ No	
	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	nsurance p	rogram (see ERISA se	ection 4	021)?		Yes No	Not determined	
	If "Yes" is checked, enter the My PAA confirmation number from the \ensuremath{If}	e PBGC p	remium filing for this pl	lan yea	r			(See instructions.)	
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning (of Year			(b) Er	nd of Year	
а	Total plan assets	7a	23	31128				189859	
b	Total plan liabilities	7b		0				0	
С	Net plan assets (subtract line 7b from line 7a)	7с	23	31128				189859	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Total	
а	Contributions received or receivable from: (1) Employers	8a(1)		0					
	(2) Participants	8a(2)		0					
	(3) Others (including rollovers)	8a(3)		0					
b	Other income (loss)	8b		7731					
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						7731	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	4	49000					
е	Certain deemed and/or corrective distributions (see instructions)	8e		0					
f	Administrative service providers (salaries, fees, commissions)	8f		0					
g	Other expenses	8g	0						
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					49000		
<u></u>	Net income (loss) (subtract line 8h from line 8c)	8i					-41269		
j	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 3D 3H	feature co	des from the List of Pla	an Cha	racteri	stic Co	odes in the in	nstructions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Plan	n Chara	acteris	tic Cod	des in the ins	structions:	
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)			10a		X			
	b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)			10b		X			
C	Was the plan covered by a fidelity bond?			10c	X			18986	
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?			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.)			10e		X			
f	f Has the plan failed to provide any benefit when due under the plan?					X			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g	X			137718	
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 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										
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.)									
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	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?		X Yes		lo					
	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?										
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	B) PN(s)					

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Luber Employee Bereatts Security Administration

Pension Benefit Gueranty 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 Ar	inual Report	Identification Information	The state of the s	nati decidità to the Porti	3300-31					
For calendar pla	n year 2018 or fi	scal plan year beginning	01/01/2018	and ending		12/31/201	0			
A This return/re	eport is for:	a single-employer plan	a multiple-employe	r plan (not multiemployer) employer information in a	(Filers	checking this he	ny must altach a			
B This return/re	port is	a one-participant plan	a foreign plan		200010111	ice with the tott	n maductions, j			
1	,	the first return/report	the final return/repo	ort						
C Check box if	60°	an amended return/report	a short plan year re	turn/report (less than 12 r	months)					
C Check box if	niing under:	Form 5558 special extension (enter description)	automatic extensio	תי	DF	VC program				
Part II Ba	sic Plan Info	rmation—enter all requested m								
1a Name of pla	n	mation—enter all requested in	lormation		1 33					
		ament, Inc. Profit Sh	naring Plan		5	Three-digit olan number	2.00			
						PN) F Effective date of	002			
2a Plan sponso	r's name (employ	ver, if for a single-employer plan)				01/01/200	0			
Mailing addr	ass (include roon	n, apt., sulto no. and street, or P.O e, country, and ZIP or foreign posts inent, Inc.). Box) al code (if foreign, see in	nstructions)		imployer Identif EIN)1.3-408 (ication Number 5308			
D & G Medi	Cal Manage	ment, inc.	•		2c S	Sponsor's teleph (845) 354-2	none number 2444			
188 South	188 South Main Street						2d Business code (see instructions)			
New City	W1 10500					621111				
3a Plan adminis	trator's name and	d address 🖾 Same as Plan Spon	sor.		3b Administrator's EIN					
1					3c A	dministrator's te	alephone number			
4 If the name a	nd/or EIN of the	plan sponsor or the plan name has	s changed since the last	return/report filed for	4b E	IN				
a Sponsor's na	ar me bian spons Jue	sor's name, EIN, the plan name an	nd the plan number from	the last return/report.						
C Plan Name					4d P	N				
5a Total number	of participants a	t the beginning of the plan year	anders constituted that they are	en ozen benzumanaki	5a					
b Total number	of participants a	t the end of the plan year			5b					
complete this	itern),	ecount balances as of the end of the	re plan year (only define	d contribution plans	5¢					
d(1) Total numb	er of active perti-	cipants at the beginning of the plan	n year	***************************************	5d(1)					
d(2) Total numb	er of active parti-	cipants at the end of the plan year	(11) (1,7) (1,7) (1,1) (ATTENDED TO COMPANY OF THE PARTY.	5d(2)					
Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vosted				5e						
		incomplete filing of this return/ r penalties set forth in the instruction signed by an enrolled actuacy as			sa is es	inblished.				
SB or Schedule M belief, it is true, co	completed and	signed by an enrolled actuary, as	well as the electronic ve	e examined this return/report,	and to t	iding, if applicat he best of my k	ole, a Schedule nowledge and			
SIGN X	with		¥ 14/19	Marc Price						
_ 2	ture of plan adn	ninistrator	Date	Enter name of individu	al signin	g as plan admir	nistrator			
SIGN HERE Signa	ture of employe	r/blan sponsor	Date							
or Paperwork Redu	etlon Act Nation,	see the Instructions for Form \$500-S	Date	Enter name of individua	al signin	g as employer c	or plan sponsor			

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		t Identification Information							
For calend	dar plan year 2018 or	fiscal plan year beginning	01/01/2018	and ending	12/31/2				
A This re	eturn/report is for:	X a single-employer plan		plan (not multiemployer) (employer information in ac					
P This res	turn/report is	a one-participant plan	a foreign plan			,			
D IIIISTE	turn/report is	the first return/report	the final return/repor						
		an amended return/report	a short plan year ret	urn/report (less than 12 m	ionths)				
C Check	box if filing under:	X Form 5558	automatic extension	1	DFVC program				
Part II	Pasia Blan Inf								
1a Name		ormation—enter all requested in	formation		46 = 0.00				
	Medical Manag	1b Three-digit plan numbe	r 002						
					1c Effective da 01/01/2	te of plan			
Mailin	g address (include ro	loyer, if for a single-employer plan) om, apt., suite no. and street, or P.C			2b Employer Identification Number (EIN)13-4086308				
City o B & G	rtown, state or provin Medical Manag	nce, country, and ZIP or foreign post gement, Inc.	tal code (if foreign, see ins	structions)	2c Sponsor's telephone number (845) 354–2444				
					2d Business code (see instructions)				
	uth Main Stre	eet							
New City NY 10956						621111			
3a Plan administrator's name and address 🗵 Same as Plan Sponsor.					3b Administrator's EIN				
3c Administrator's telephone number									
4 If the this p	lan, enter the plan sp	ne plan sponsor or the plan name ha onsor's name, EIN, the plan name a	as changed since the last and the plan number from	the last return/report.	4b EIN				
a Spons C Plan N	sor's name Name				4d PN				
5a Total	number of participant	s at the beginning of the plan year		***************************************	5a	10			
		s at the end of the plan year			5b	10			
comp	lete this item)	account balances as of the end of	701000000000000000000000000000000000000		5c	10			
		articipants at the beginning of the pl			5d(1)	4			
		articipants at the end of the plan yea o terminated employment during the			5d(2)	4			
than	100% vested	or incomplete filing of this return	************		5e	0			
Under pena SB or Sche	alties of perjury and o	ther penalties set forth in the instruction and signed by an enrolled actuary, a	tions, I declare that I have	e examined this return/ret	port, including, if a	pplicable, a Schedule			
SIGN				Marc Price					
	Signature of plan a	administrator	Date	Enter name of individu	ual signing as plan	administrator			
SIGN	Ciamaturf!		D-4						
F 6	Signature of emplo	byenplan sponsor	Date	Enter name of individu	iai signing as emp	oyer or plan sponsor			

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Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)									
Part III Financial Information									
7 Plan Assets and Liabilities		(a) Beginning (of Year			(b) End o	f Year		
a Total plan assets	7a		231	,128				189,859	
b Total plan liabilities				0				0	
C Net plan assets (aubtract line 7b from line 7a)	7°c		231	,128	_			189,859	
8 Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t	-		(b) To	ital		
Contributions received or receivable from: (1) Employers	8a(1)			0					
(2) Participants				0					
(3) Others (including rollovers)				0					
b Other Income (loss)			7	,731					
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							7,731	
d Benefits paid (including direct rollovers and insurance premiums	0.4		40	.000					
to provide benefits). • Certain deemed and/or corrective distributions (see instructions)	<u>8d</u> . Be		4.	000,					
f Administrative service providers (sataries, fees, commissions)	_			0					
g Other expenses	1			0					
h Total expenses (add lines 8d, 8e, 8f, and 8g)	7							49,000	
Net income (loss) (subtract line 8h from line 8c)	1							-41,269	
j Transfers to (from) the plan (see instructions)									
Part IV Plan Characteristics	1 1								
92 If the plan provides pension benefits, enter the applicable pension	n feature cod	des from the List of Pl	en Che	racteri	stic Code	s in the instru	uctions:		
Pension benefits 2A 2E 3D 3H	- 1	The state of Man	~			- W - No adam	**		
b if the plan provides welfare benefits, enter the applicable welfare Welfare benefits	feature coue	es from the List of Miai	n Char	acteris	tic Codes	in the Instruc	ctions:		
Part V Compliance Questions									
10 During the plan year:				Yes	No	A	mount		
Was there a failure to transmit to the plan any participant contrib described in 29 CFR 2510.3-1027 (See instructions and DOL's Program)	Voluntary Fi	duciary Correction	10a		×				
b Were there any nonexempt transactions with any party-in-interes			,,,,,						
reported on line 10a.)	minetime.		10b	_	×				
C Was the plan covered by a fidelity bond?		w	10c	×				18,986	
d Did the plan have a loss, whether or not reimbursed by the plan by fraud or dishonesty?	carried Handard		10d		×				
 Were any fees or commissions paid to any brokers, agents, or of carrier, insurance service, or other organization that provides so the plan? (See Instructions). 	me or all of t	he benefits under	10e		×				
f Has the plan failed to provide any benefit when due under the plan	an?		10f		×				
g Did the plan have any participant loans? (If "Yes," enter amount	as of year-ei	nd.)	10g	×				137,718	
h If this is an individual account plan, was there a blackout period?	(See Instru	ctions and 29 CFR		-				12141.13	
i If 10h was enswered "Yes," check the box if you either provided			10h	_	×				
exceptions to providing the notice applied under 29 CFR 2520.1			101						
			-		-				

	Form 5500-SF (2018)		Page 3-					
Part	VI Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum (Form 5500) and line 11a below)					В	Ye	s X No
11a	Enter the unpaid minimum required contribution	s for all years from Schedule S	B (Form 5500) line 40		11a			
12	Is this a defined contribution plan subject to the ERISA?				1 302 o	f	Ye	s X No
-	(If "Yes," complete line 12a or lines 12b, 12c, 1							
a 	If a waiver of the minimum funding standard for granting the waiver.	. , ,			l enter t Day		he letter r Year	ruling
lf	you completed line 12a, complete lines 3, 9, a	nd 10 of Schedule MB (Form	5500), and skip to lin	e 13.				
b	Enter the minimum required contribution for this	plan year	010001111111111111111111111111111111111		12b			
С	Enter the amount contributed by the employer to	the plan for this plan year	511115111111111111111111111111111111111	wasan karanga	12c			
d	Subtract the amount in line 12c from the amount negative amount)	,	0		12d			
е	Will the minimum funding amount reported on li	ne 12d be met by the funding d	eadline?			Yes	No 📗	N/A
Part	VII Plan Terminations and Transfer	s of Assets						
13a	Has a resolution to terminate the plan been adopte	d in any plan year?				X Yes	No	
-	If "Yes," enter the amount of any plan assets th	at reverted to the employer this	year		13a			(
b	Were all the plan assets distributed to participal control of the PBGC7		to another plan, or bro	ought under the			Yes X	No
С	If, during this plan year, any assets or liabilities which assets or liabilities were transferred. (See	·	to another plan(s), ide	ntify the plan(s)	to			

13c(2) EIN(s)

13c(3) PN(s)

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