

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment 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**2021****This Form is Open to
Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021**A** This return/report is for: ☒ 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.)**B** This return/report is ☐ the first return/report ☐ the final return/report
☐ 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
☐ special extension (enter description)**D** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ☐**Part II Basic Plan Information—enter all requested information**

1a Name of plan <u>FITNESS & RECOVERY MEDICAL PRACTICE, PC 401(K) PLAN</u>	1b Three-digit plan number (PN) ▶ <u>001</u>												
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) <u>FITNESS & RECOVERY MEDICAL PRACTICE, PC</u> <u>369 WHITE PLAINS ROAD</u> <u>EASTCHESTER, NY 10709</u>	1c Effective date of plan <u>01/01/2011</u>	2b Employer Identification Number (EIN) <u>26-3925875</u> 2c Sponsor's telephone number <u>914-395-3691</u> 2d Business code (see instructions) <u>621111</u>											
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN 3c Administrator's telephone number	4b EIN 4d PN											
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	<table border="1"> <tr> <td data-bbox="1161 1354 1274 1407">5a</td> <td data-bbox="1274 1354 1562 1407"><u>13</u></td> </tr> <tr> <td data-bbox="1161 1407 1274 1459">5b</td> <td data-bbox="1274 1407 1562 1459"><u>16</u></td> </tr> <tr> <td data-bbox="1161 1459 1274 1512">5c</td> <td data-bbox="1274 1459 1562 1512"><u>7</u></td> </tr> <tr> <td data-bbox="1161 1512 1274 1564">5d(1)</td> <td data-bbox="1274 1512 1562 1564"><u>8</u></td> </tr> <tr> <td data-bbox="1161 1564 1274 1617">5d(2)</td> <td data-bbox="1274 1564 1562 1617"><u>11</u></td> </tr> <tr> <td data-bbox="1161 1617 1274 1621">5e</td> <td data-bbox="1274 1617 1562 1621"><u>0</u></td> </tr> </table>	5a	<u>13</u>	5b	<u>16</u>	5c	<u>7</u>	5d(1)	<u>8</u>	5d(2)	<u>11</u>	5e	<u>0</u>
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Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	09/19/2022	ANGELO NATOLI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/19/2022	ANGELO NATOLI
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

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v.201209

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	311045	399033
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	311045	399033
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	6720	
(2) Participants	8a(2)	19500	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	62646	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		88866
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	878	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		878
i Net income (loss) (subtract line 8h from line 8c)	8i		87988
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2F 2G 2J 2K 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:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		40000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	X		26838
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 exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below. ☐ Yes ☒ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

b **PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation _____

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.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above. ☐ Yes ☒ No

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

c Enter the amount contributed by the employer to the plan for this plan year **12c**

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

e Will the minimum funding amount reported on line 12d be met by the funding deadline? ☐ 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 ☒ 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 ☒ No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

E-SIGNATURE AUTHORIZATION

for

Fitness & Recovery Medical Practice, PC 401(k) Plan

26-3925875/001

For Plan Year 01/01/2021 through 12/31/2021


I/We, the undersigned, understand that a 5500 Series filing for the plan listed above must be prepared, electronically signed and electronically transmitted to the EBSA Electronic Filing Acceptance System (EFAST).

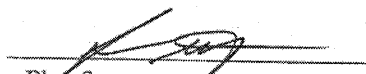
I/We authorize Pension Parameters Financial Services, Inc. to electronically sign the 5500 Series filing on my/our behalf and to transmit that signed form to EFAST on or before the filing due date.

I/We understand that by granting this authority:

- A manually signed and dated Form 5500-SF that has been provided must be returned to Pension Parameters Financial Services, Inc. before they can begin the electronic filing process. I/We will retain a copy of this manually signed form and any schedules and attachments in the plan records.
- Pension Parameters Financial Services, Inc. will not be responsible for any late filing penalty assessed under ERISA should I/we not return the manually signed and dated Form 5500-SF prior to the filing due date.
- An electronic copy of the manually signed and dated Form 5500-SF showing my/our signatures will be included in the electronic filing and will be posted by the EBSA to the Internet for public disclosure.
- Pension Parameters Financial Services, Inc. will maintain a copy of this written authorization in its records.
- Pension Parameters Financial Services, Inc. will notify all signers about any inquiries and correspondence it receives about this filing from EFAST, EBSA, IRS or PBGC.
- Pension Parameters Financial Services, Inc. shall not be deemed to be a plan fiduciary with respect to this plan solely on account of providing the electronic signature and filing of the 5500-SF for the plan year listed above.


Plan Administrator


Date


Plan Sponsor


Date

Form 5500-SF

Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty CorporationShort Form Annual Return/Report of Small Employer
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

2021

This Form is Open to
Public Inspection**Part I Annual Report Identification Information**

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

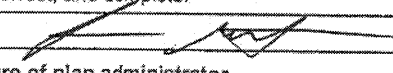
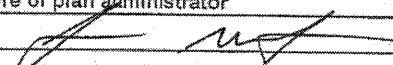
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☐ special extension (enter description)

D If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ☐**Part II Basic Plan Information** — enter all requested information

1a Name of plan Fitness & Recovery Medical Practice, PC 401(k) Plan		1b Three-digit plan number (PN) ▶ 001
		1c Effective date of plan 01/01/2011
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) Fitness & Recovery Medical Practice, PC 369 White Plains Road US Eastchester NY 10709		2b Employer Identification Number (EIN) 26-3925875 2c Sponsor's telephone number (914) 395-3691 2d Business code (see instructions) 621111
3a Plan administrator's name and address <input checked="" type="checkbox"/> 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		4b EIN 4d PN
5a Total number of participants at the beginning of the plan year	5a	13
b Total number of participants at the end of the plan year	5b	16
c 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	5d(1)	8
d(2) Total number of active participants at the end of the plan year	5d(2)	11
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0

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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		9/19/22	ANGELO NATOLI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		9/19/22	ANGELO NATOLI
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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