

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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold; font-size: 1.2em;">2021</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> 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	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)
D If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. <input type="checkbox"/>	

Part II Basic Plan Information —enter all requested information													
1a Name of plan <u>METRO PHYSICAL THERAPY & SPORTS REHAB, LLP 401(K) PS PLAN</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">1b Three-digit plan number (PN) ▶</td> <td style="width:40%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2007</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>01/01/2007</u>									
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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>METRO PHYSICAL THERAPY & SPORTS REHABILITATION, LLP</u> <u>4 EAST 84TH STREET</u> <u>NEW YORK, NY 10028</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">2b Employer Identification Number (EIN) <u>13-4079934</u></td> <td style="width:40%;"></td> </tr> <tr> <td>2c Sponsor's telephone number <u>212-585-4444</u></td> <td></td> </tr> <tr> <td>2d Business code (see instructions) <u>446190</u></td> <td></td> </tr> </table>	2b Employer Identification Number (EIN) <u>13-4079934</u>		2c Sponsor's telephone number <u>212-585-4444</u>		2d Business code (see instructions) <u>446190</u>							
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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. a Sponsor's name c Plan Name	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">4b EIN</td> <td style="width:40%;"></td> </tr> <tr> <td>4d PN</td> <td></td> </tr> </table>	4b EIN		4d PN									
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5a Total number of participants at the beginning of the plan year b Total number of participants at the end of the plan year c Number of participants with account balances as of the end of the plan year (only defined contribution plans 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 e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">5a</td> <td style="width:40%; text-align: center;"><u>6</u></td> </tr> <tr> <td>5b</td> <td style="text-align: center;"><u>5</u></td> </tr> <tr> <td>5c</td> <td style="text-align: center;"><u>5</u></td> </tr> <tr> <td>5d(1)</td> <td style="text-align: center;"><u>6</u></td> </tr> <tr> <td>5d(2)</td> <td style="text-align: center;"><u>5</u></td> </tr> <tr> <td>5e</td> <td style="text-align: center;"><u>0</u></td> </tr> </table>	5a	<u>6</u>	5b	<u>5</u>	5c	<u>5</u>	5d(1)	<u>6</u>	5d(2)	<u>5</u>	5e	<u>0</u>
5a	<u>6</u>												
5b	<u>5</u>												
5c	<u>5</u>												
5d(1)	<u>6</u>												
5d(2)	<u>5</u>												
5e	<u>0</u>												

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.	09/30/2022	GREGG SOLOMON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/30/2022	GREGG SOLOMON
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 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	896913	978726
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	896913	978726
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	3994	
(2) Participants	8a(2)	54703	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	80224	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		138921
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	47662	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	9446	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		57108
i Net income (loss) (subtract line 8h from line 8c)	8i		81813
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 2J 2R 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	
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		9446
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 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)

PENSION PLAN DESIGN SERVICES
CONSULTING • PLAN DESIGN • ADMINISTRATION

P.O. Box 3721, Kingston, NY 12402
845-481-4168 • peg008@aol.com

September 28, 2022

Mr. Gregg Solomon
Mr. Lior Cohen
Metro Physical Therapy & Sports Rehab, LLP.
4 East 84th Street
New York, New York 10028.

RE: Authorization for Third Party Administrator to file Government forms

Dear Mr. Solomon and Mr. Cohen:

I hereby authorize Pension Plan Design Service (Patricia Guida) as Third Party Administrator to electronically sign and file the government forms for the plan year ending 12/31/2021 for Metro Physical Therapy & Sports Rehab, LLP 401(k) Plan thru EFAST2.


Part I - I understand that in granting this authority:

- (A) I must manually sign and date page 1 of the form 5500SF and return forms to Pension Plan Design Service after I have reviewed the forms provided and will retain a copy of this written authorization for our records.
- (B) Pension Plan Design Service will notify the individual who signs as Plan Administrator (on page 1 of the form) any inquiries and information received by EFAST2, the Department of Labor or IRS.
- (C) A copy of my signature, as it appears on Page 1 of form 5500 will be included with the return/report posted by the Department of Labor on the Internet for Public Disclosure.
- (D) Pension Plan Design Service shall not be deemed an administrator or Fiduciary with respect to any Plan solely on account of the services performed under this authorization.

This authorization is applicable on to the filing for the named Plan and applied only for the plan year ending 12/31/2021.

PLAN ADMINISTRATOR

DATE

9/30/22


PART II

On behalf of Pension Plan Design Service, I certify that the firm will use this Authority granted for the express purposes described above, that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST filing, and that the firm will take reasonable steps to assure that confidential information provided by the Plan Administrator or Plan Sponsor is protected from unauthorized disclosure

PENSION PLAN DESIGN SERVICE

DATE

10/1/2022

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 Employee
Benefit PlanThis 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).OMB Nos. 1510-0110
1510-0089

2021

This Form is Open to
Public Inspection

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

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:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> 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:	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report	
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C	Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
		<input type="checkbox"/> special extension (enter description)		
D	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here <input type="checkbox"/>			

Part II Basic Plan Information --- enter all requested information

1a	Name of plan METRO PHYSICAL THERAPY & SPORTS REHAB, LLP 401(k) PS PLAN	1b	Three-digit plan number (PN) ▶	001
		1c	Effective date of plan	01/01/2007
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) METRO PHYSICAL THERAPY & SPORTS REHABILITATION, LLP 4 EAST 84TH STREET US NEW YORK NY 10028	2b	Employer Identification Number (EIN)	13-4679934
		2c	Sponsor's telephone number	(212) 585-4444
		2d	Business code (see instructions)	445190
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.	4b	EIN	
a	Sponsor's name	4d	PN	
c	Plan Name			
5a	Total number of participants at the beginning of the plan year	5a		6
b	Total number of participants at the end of the plan year	5b		5
c	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c		5
d(1)	Total number of active participants at the beginning of the plan year	5d(1)		6
d(2)	Total number of active participants at the end of the plan year	5d(2)		5
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 belief, it is true, correct, and complete.

Sign Here

SIGN HERE		Date	01-30-21	Enter name of individual signing as plan administrator	G. K. K. Solomon
SIGN HERE		Date	01-30-21	Enter name of individual signing as employer or plan sponsor	G. K. K. Solomon

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

Form 5500-SF (2021)
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