Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 12/01/2008 and ending 11/30/2009

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

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 If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
GASTROCARE DBA DIGESTIVE CARE HEALTH PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
GASTROCARE, LLP

2902 N. UNIVERSITY DRIVE
CORAL SPRINGS, FL 33065

2902 N. UNIVERSITY DRIVE
CORAL SPRINGS, FL 33065

2b Employer Identification Number (EIN)
20-3207949

2c Sponsor's telephone number

2d Business code (see instructions)

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 accompanying schedules, statements and attachments, 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			
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

GASTROCARE, LLP

2902 N. UNIVERSITY DRIVE
CORAL SPRINGS, FL 33065

3b Administrator's EIN
20-3207949

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a Plan funding arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- **(1)** ☐ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information)
- **(4)** ☐ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of 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 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

Official Use Only
OMB Nos. 1210 – 0110
1210 – 0089

2008

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning 12/01/2008, **and ending** 11/30/2009,

A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple–employer plan; or
(2) ☒ a single–employer plan (other than a multiple–employer plan); (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively–bargained plan, check here ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ▶ ☐

Part II Basic Plan Information – – enter all requested information.

1a Name of plan
GASTROCARE DBA DIGESTIVE CARE HEALTH PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan (mo., day, yr.) 12/01/2006

2a Plan sponsor's name and address (employer, if for a single–employer plan)
(Address should include room or suite no.)
GASTROCARE, LLP

2902 N. UNIVERSITY DRIVE

CORAL SPRINGS FL 33065

2b Employer Identification Number (EIN) 20-3207949

2c Sponsor's telephone number 954-344-2552

2d Business code (see instructions) 621111

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 accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete

SIGN HERE	Lauren Schary	6/29/10	Lauren Schary
	Signature of plan administrator	Date	Type or print name of individual signing as plan administrator
SIGN HERE	Lauren Schary	6/29/10	Lauren Schary
	Signature of employer/plan sponsor/DFE	Date	Type or print name of individual signing as employer, plan sponsor or DFE

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3a Plan administrator's name and address (If same as plan sponsor, enter "Same") SAME	**3b** Administrator's EIN **3c** Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name	**b** EIN **c** PN
5 Preparer information (optional) **a** Name (including firm name, if applicable) and address	**b** EIN **c** Telephone number

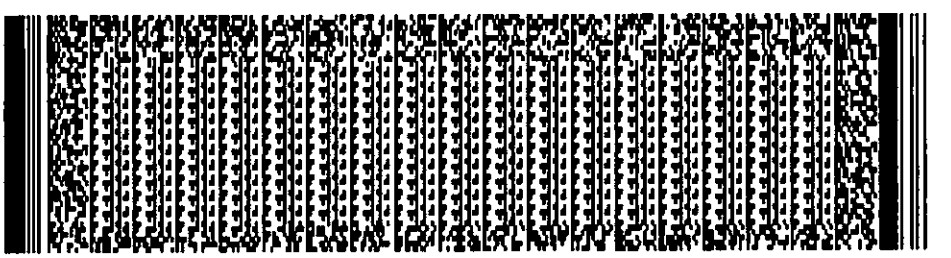
6	Total number of participants at the beginning of the plan year	6	169
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	7a	281
b	Retired or separated participants receiving benefits	7b	
c	Other retired or separated participants entitled to future benefits	7c	
d	Subtotal. Add lines **7a, 7b,** and **7c**	7d	281
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	
f	Total. Add lines **7d** and **7e**	7f	281
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a [ ] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b [X] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): 4A

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts	(2) [ ] Code section 412(i) insurance contracts
(3) [ ] Trust	(3) [ ] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor



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10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1)	☐	R	(Retirement Plan Information)
(2)	☐	B	(Actuarial Information)
(3)	☐	E	(ESOP Annual Information)
(4)	☐	SSA	(Separated Vested Participant Information)

b Financial Schedules

(1)	☐		H	(Financial Information)
(2)	☐		I	(Financial Information – – Small Plan)
(3)	☒	1	A	(Insurance Information)
(4)	☐		C	(Service Provider Information)
(5)	☐		D	(DFE/Participating Plan Information)
(6)	☐		G	(Financial Transaction Schedules)

0 2 0 8 7 6 0 3 0 Q

SCHEDULE A
(Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.
▶ **File as an attachment to Form 5500.**
▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only
OMB No. 1210-0110
2008
This Form is Open to Public Inspection.

For calendar plan year 2008 or fiscal plan year beginning 12/01/2008 and ending 11/30/2009

A Name of plan
GASTROCARE DBA DIGESTIVE CARE HEALTH PLAN

B Three-digit plan number ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
GASTROCARE, LLP

D Employer Identification Number
20-3207949

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

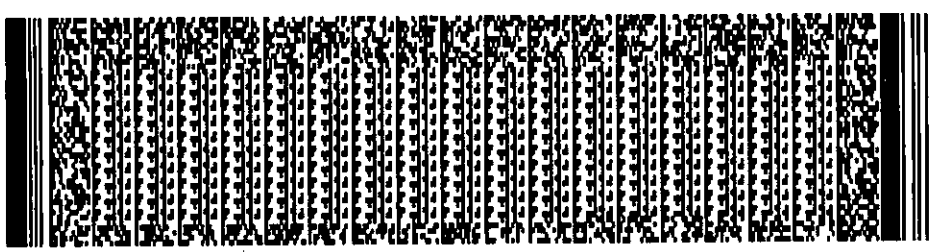
AETNA INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
06-6033492	60054	474308-ERG	281	12/01/2008	11/30/2009

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid	Total fees paid / amount
53732	0



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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

DAVID B ADAMS
600 CORPORATE DRIVE SUITE 650
FORT LAUDERDALE FL 33334

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
26866	0		3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

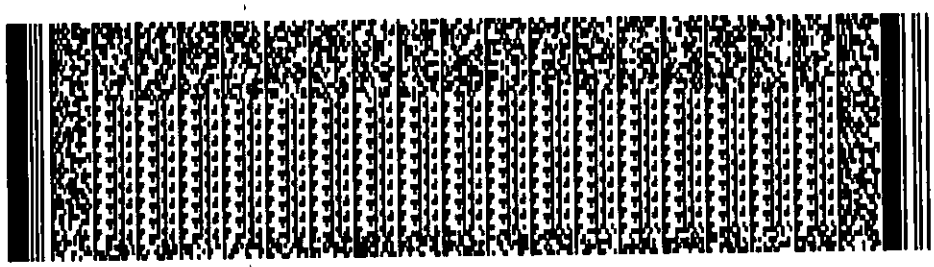
PINETREE CAPITAL LLC
5511 UNIVERSITY DRIVE
CORAL SPRINGS FL 33067

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
9745	0		3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

TODD BROWN
5511 UNIVERSITY DRIVE
CORAL SPRINGS FL 33067

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
17121	0		3



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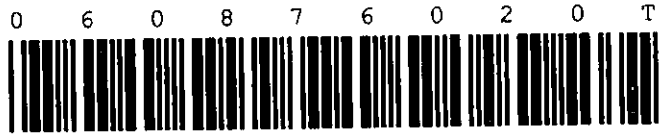
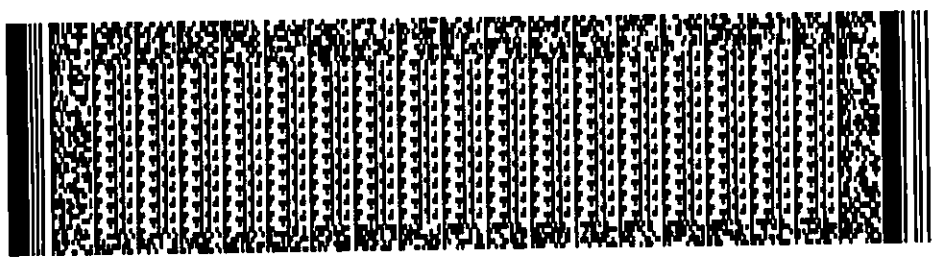


Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	
c	Premiums due but unpaid at the end of the year	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	
	Specify nature of costs ▶	
e	Type of contract (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other (specify below) ▶	
b	Balance at the end of the previous year	0
c	Additions: (1) Contributions deposited during the year	
	(2) Dividends and credits	
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below) ▶	
	(6) Total additions	0
d	Total of balance and additions (add b and c(6))	0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below) ▶	
	(5) Total deductions	0
f	Balance at the end of the current year (subtract e(5) from d)	0



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Part III Welfare Benefit Contract Information

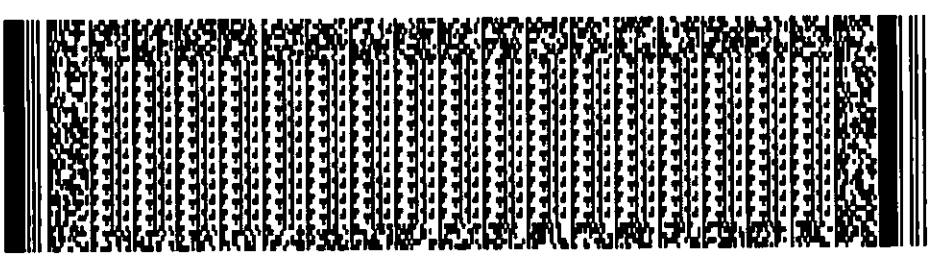
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

a [X]	Health (other than dental or vision)	**b** [ ]	Dental	**c** [ ]	Vision	**d** [ ]	Life Insurance
e [ ]	Temporary disability (accident and sickness)	**f** [ ]	Long-term disability	**g** [ ]	Supplemental unemployment	**h** [X]	Prescription drug
i [ ]	Stop loss (large deductible)	**j** [ ]	HMO contract	**k** [X]	PPO contract	**l** [ ]	Indemnity contract
m [ ]	Other (specify) ▶						

8	Experience-rated contracts		
a	Premiums: (1) Amount received		
	(2) Increase (decrease) in amount due but unpaid		
	(3) Increase (decrease) in unearned premium reserve		
	(4) Earned ((1) + (2) - (3))		0
b	Benefit charges: (1) Claims paid		
	(2) Increase (decrease) in claim reserves		
	(3) Incurred claims (add (1) and (2))		0
	(4) Claims charged		
c	Remainder of premium: (1) Retention charges (on an accrual basis) –		
	(A) Commissions		
	(B) Administrative service or other fees		
	(C) Other specific acquisition costs		
	(D) Other expenses		
	(E) Taxes		
	(F) Charges for risks or other contingencies		
	(G) Other retention charges		
	(H) Total retention		0
	(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
	(2) Claim reserves		
	(3) Other reserves		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
9	Nonexperience-rated contracts:		
a	Total premiums or subscription charges paid to carrier		1160133
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		

Specify nature of costs ▶



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