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 section 6058(a) of the Internal Revenue Code (the Code).

1210-0089

OMB Nos. 1210-0110

2009

This Form is Open to Public Inspection

Pe	ension Benefit Guaranty Corp	oration	▶ Complete all entries in accor	dance witl	h the instructions to the Form 5500	O-SF.		peotion			
Pa	rt I Annual Re	eport Ide	entification Information				-				
For	calendar plan year 200			9	and ending 1	2/31/2	2009				
Α 7	This return/report is for	_r X	single-employer plan	multiple-e	employer plan (not multiemployer)		one-participa	nt plan			
	This return/report is for		first return/report	final retur			ш	•			
,	This return/report is for	'·	an amended return/report		n year return/report (less than 12 mor	othe)					
_			Form 5558		• •	1015)	П				
C	Check box if filing unde	extension		☐ DFVC progra	ım						
			special extension (enter description	on)							
Pa	rt II Basic Plai	n Inform	nation—enter all requested inform	ation							
	Name of plan					1b	Three-digit				
CARI	NG HEALTH CLINIC I	PROFIT S	HARING PLAN				plan number	001			
					•	4.	(PN) •				
						10	Effective date of 01/01/2				
2a	Dlan enoneor's name	and addre	ss (employer, if for single-employer	nlan)		2h	Employer Identi		or		
	NG HEALTH CLINIC,		ss (employer, il lor single-employer	piai i)		20	(EIN) 64-091)CI		
						2c	Plan sponsor's t	elephone nur	nber		
	N. MEDICAL PARK D						662-33				
GREE	ENVILLE, MS 38703-7	7239				2d	Business code (see instructio	ns)		
32	Plan administrator's n	ama and a	address (if same as Plan sponsor, e	ntor "Same	\ <u>\</u> \\	3h	621111	EINI			
	NG HEALTH CLINIC,		1542 N. MEL			3b Administrator's EIN 64-0918650					
			GREENVILL	E, MS 387	03-7239	3c Administrator's telephone num					
							662-33				
			n sponsor has changed since the la		port filed for this plan, enter the	4b EIN					
r	name, EIN, and the pia	an number	from the last return/report. Sponso	ors name		4c	C PN				
5a	Total number of partic	cinants at	the beginning of the plan year			5a	T		7		
_	•	•			ł						
	•	•	the end of the plan year		ł	5b			0		
C	•	•	h account balances as of the end o		ear (defined benefit plans do not	5c			0		
6a					(See instructions.)		I	X Yes	No		
					ndent qualified public accountant (IQF						
					ons.)			X Yes	No		
_				orm 5500-	SF and must instead use Form 550	00.					
Pa	rt III Financial	Informa	tion								
7	Plan Assets and Liab	ilities			(a) Beginning of Year		(b) End	of Year			
а	Total plan assets			. 7a	553576	5			0		
b	Total plan liabilities			. 7b	0)					
С	Net plan assets (subt	ract line 7	o from line 7a)	7с	553576	5			0		
8	Income, Expenses, a	nd Transfe	ers for this Plan Year		(a) Amount		(b) 1	Γotal			
а	Contributions receive										
	(1) Employers			1		_					
	(2) Participants			. 8a(2)		_					
	(3) Others (including	rollovers)		. 8a(3)							
b	Other income (loss)			. 8b							
C	Total income (add line	es 8a(1), 8	sa(2), 8a(3), and 8b)	. 8c					0		
d			ollovers and insurance premiums	. 8d	553576	<u>. </u>					
е	Certain deemed and/	or correcti	ve distributions (see instructions)	. 8e							
f	Administrative service	e providers	s (salaries, fees, commissions)	. 8f							
g											
h	·		e, 8f, and 8g)					55	3576		
i			8h from line 8c)					-55	3576		
j			e instructions)								
-		-		, J	1						

Form 5500-SF 2009	Page 2- 1
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Part IV	Dlan	Characteristics	_
Partiv	Pian	Characteristics	۰

Filed with authorized/valid electronic signature.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of plan administrator

SIGN HERE

SIGN HERE

9a 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:

art	V Compliance Questions							
0	During the plan year:		Yes	No		Amo	unt	
а	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				
С	Was the plan covered by a fidelity bond?	10c		Χ				
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	Has the plan failed to provide any benefit when due under the plan?	10f		Χ				
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		Χ				
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						
art	VI Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and comp 5500))						Yes	X No
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code	or se	ction 3	02 of E	ERISA?		Yes	X No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)							
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruction granting the waiver							
	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.		Г	40h				
	Enter the minimum required contribution for this plan year		–	12b				
	Enter the amount contributed by the employer to the plan for this plan year			12c				
a	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of negative amount)		L	12d				
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	١	10	N/A
art	VII Plan Terminations and Transfers of Assets							
3a	Has a resolution to terminate the plan been adopted during the plan year or any prior year?					X	Yes	No
	If "Yes," enter the amount of any plan assets that reverted to the employer this year			13a				0
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought upon the PBGC?	under	the co			X	Yes	No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify th which assets or liabilities were transferred. (See instructions.)	ne plai	n(s) to					
1	3c(1) Name of plan(s):		130	(2) EII	V(s)		13c(3)	PN(s)
Caut	ion: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable	le cau	se is	establi	shed.			
Jnde SB o	er penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/r f, it is true, correct, and complete.	ırn/rep	ort, in	cluding	g, if applic	,		

09/02/2010

09/02/2010

Date

Date

AMITA N. PATEL

AMITA N. PATEL

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

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 section 6058(a) of the Internal Revenue Code (the Code).

2009

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection.

	Pension Benefit Guaranty Corporation ► Complete all	entries in acco	rdance with	the instructions to the Form 5500-	SF.					
-	art I Annual Report Identification Ir									
For	r the calendar plan year 2009 or fiscal plan year be	ginning	2009-	-01-01 and ending	20	009-12-31				
Α	This return/report is for:	ian [] multiple-er	mployer plan (not multiemployer)		one-participar	nt plan			
В	This return/report is for: first return/report	3	final return	/report						
	an amended retu	n/report	short plan	year return/report (less than 12 months))					
С	C Check box if filling under:						n			
	special extension	(enter descriptio	n) -							
Ь	art II Basic Plan Information enter									
	Name of plan	an requested mic	illiadori.		1b	Three-digit	1-11-11-11-11-11-11-11-11-11-11-11-11-1			
	·	- Di				plan number	001			
	Caring Health Clinic Profit Sharin	g Plan		_		(PN) ► Effective date of				
						2000-01-01	pian			
2a	Plan sponsor's name and address (employer, if for	single-employer i	olan)			Employer Identif				
	Caring Health Clinic, PC					(EIN) 64-091				
	1542 N. Medical Park Drive				ZC	Plan sponsors to (662) 334-6	elephone number 448			
					2d	Business code (s				
	Greenville MS 38703-		, 10 H		2 h	621111	-181			
зa	Plan administrator's name and address (If same as Same	plan employer, e	nter "Same")	SD	Administrator's E	:IIN			
				<u> </u>						
					3c Administrator's telephone nu					
4	If the name and/or EIN of the plan sponsor has channed EIN and the plan number from the last return			ort filed for this plan, enter the	4b	EIN				
	name, EIN and the plan number from the last return	. Sponsors Nam	6		4c	PN				
5a	Total number of participants at the beginning of the	plan year			5a		7			
b	Total number of participants at the end of the plan y			·	<u>5b</u>		0			
С	Total number of participants with account balances complete this item)				5c		0			
6a	Were all of the plan's assets during the plan year in						X Yes No			
b	Are you claiming a waiver of the annual examination	and report of ar	n independer	nt qualified public accountant (IQPA)						
	under 29 CFR 2520.104-46? (See instructions on w			•			X Yes No			
27-112-1	If you answered "No" to either 6a or 6b, the plan	cannot use For	m 5500-SF a	and must instead use Form 5500.						
	art III Financial Information		The state of the s	(2) B		(h) Fd	-6 V			
7	Plan Assets and Liabilities			(a) Beginning of Year		(b) End				
a h	Total plan assets		. 7a	553,576			0			
b	Total plan liabilities		. 7b	0			0			
<u> </u>	Net plan assets (subtract line 7b from line 7a) .	• • • • •	. 7c	553,576						
8	Income, Expenses, and Transfers for this Plan Year		\$2000 miles (1900)	(a) Amount	\$20000E	(b) T	otal			
а	Contributions received or receivable from: (1) Employers		. 8a(1)							
	(2) Participants		. 8a(2)							
	(3) Others (including rollovers)		. 8a(3)							
b	Other income (loss)		. 8b							
Ç	Total income(add lines 8a(1), 8a(2), 8a(3), and 8b)		. 8c				0			
d	Benefits paid (including direct rollovers and insurance									
	to provide benefits)		· 8d	553,576						
6	Certain deemed and/or corrective distributions (see	•	. 8e							
f	Administrative service providers (salaries, fees, com	missions)	. 8f							
g	Other expenses		· 8g				EFO CCC			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)		. 8h				553,576			
ĺ	Net income (loss) (subject line 8h from line 8c)		. 8i				(553,576)			
j	Transfers to (from) the plan (see instructions)		. 8j							

Par	IV Plan Characteristics								
9a :	f the plan provides pension benefits, enter the applicable pension feat	ure codes from the Li	st of Plan Characte	ristic (Codes	In the	instructions:		
b I	2E f the plan provides welfare benefits, enter the applicable welfare feature	re codes from the List	t of Plan Characteri	stic Co	odes li	n the ir	nstructions:		
Par	V Compliance Questions								
10	During the plan year:				Yes	No	Ar	nount	
а	Was there a failure to transmit to the plan any participant contribution	within the time perio	od described in						
	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary	y Correction Program)	10a		Х			
a	Were there any nonexempt transactions with any party-in-interest? (I on line 10a.)		-	10b		x			
_	,			10c		х			
c d	Was the plan covered by a fidelity bond?								
u	or dishonesty?	-		10d		х			
е	Were any fees or commisions paid to any brokers, agents, or other p	ersons by an insuran	ce carrier,						
	Insurance services or other organization that provides some or all of			10e		х			
f	Instructions.)			10f		х			
	·					х			
g h	Did the plan have any participant loans? (If "Yes," enter amount as of if this is an individual account plan, was there a blackout period? (Se			10g					***************************************
"	2520.101-3.)			10h		х			
i	If 10h was answered "Yes," check the box if you either provided the r								
	exceptions to providing the notice applied under 29 CFR 2520.101-3			10i					
<u>Ran</u>	M Pension Funding Compliance Is this a defined benefit plan subject to minimum funding requirement	ts? (If "Ves " see inst	ructions and comple	te Sc	hedula	SB (F	Form		
	5500))							Yes X No	<u> </u>
12	Is this a defined contribution plan subject to the minimum funding req	uirements of section	412 of the Code or	sectio	ก 302	of ER	ISA?	Yes X No	ı
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable	le.)							
а	If a walver of the minimum funding standard for a prior year is being a granting the walver								
if v	granting the waiver					Day			
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					12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the	•				12d			
	negative amount)			• •	٠ ـ		☐Yes [No □N/A	
	Will the minimum funding amount reported on line 12d be met by the VII Plan Terminations and Transfers of Assets	tunding deadline? .		• •	• •	•			
			2					X Yes No	
138	Has a resolution to terminate the plan been adopted during the plan y if "Yes," enter the amount of any plan assets that reverted to the emp			• •	Ċ	13a			0
h	Were all the plan assets distributed to participants or beneficiaries, tra	· · · · · · · · · · · · · · · · · · ·							<u> </u>
N	of the PBGC?					• •		X Yes No	ı
С	If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See Instructions.)	this plan to another p	lan(s), identify the p	lan(s)	to				
1	3c(1) Name of plan(s):				13	c(2) El	N(s)	13c(3) PN(s)	
Cautio	n: A penalty for the late or incomplete filing of this return/report v	vill be assessed unl	ess reasonable ca	use Is	esta	blishe	d.		
SB or	penalties of perjury and other penalties set forth in the instructions, I d Schedule MB completed and signed by an enrolled actuary, as well as it is true, correct, and complete.	eclare that I have exa the electronic version	amined this return/repo	eport, rt, and	includ I to the	ing, if a	applicable, a of my knowle	Schedule edge and	
SIG	1 DCalely		AMITA		N		PATE	L	
HEF	DAME	Date 8-10-10	Enter name of ind	ividua	l siani				
SIG	00.7.0		AMITA		N		ATEL	* = AU	
HEF		Date 8-10-10	Enter name of ind					ian sponsor	
restance.	I oraugene of embroket/high shorteon	Date - 10 (0	Leuroi name oi ino	, y . u u d	. signi	iy as t	on project of p	act opotion	—

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Form 5500-SF (2009)

Form 5558 (Rev. January 2008) Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see Instructions on page 3.

File With IRS Only

OMB No. 1545-0212

Part I	Identification										
Ca	ne of filer, plan administrator, or plan sponsor (see instructions) ring Health Clinic, PC nber, street, and room or sulte no. (If a P.O. box, see instructions.)	B	Emplo	yer Ide	ntification nur	e r (see Instru mber (EIN).	ictions).				
	42 N. Medical Park Drive			09186 securit	y number (St	SN)					
	or town, state and ZIP code	7				,					
	eenville MS 38703-7239				B1.	n year end					
С	Plan name	Plan number			MM	Ing YYYY					
_		1	1	1							
1 <u>Ca</u>	ring Health Clinic Profit Sharing Plan		0	1 1	12	31	2009				
•			1	!							
2			<u> </u>	1							
3			L								
Part II	Extension of Time to File Form 5500 or Form 5500-EZ (see in	structio	ons)								
1 Ire	quest an extension of time until <u>10 / 15 / 2010</u> to file For	m 5500	or Fo	rm 550	00-EZ.						
nor	application is automatically approved to the date shown on line 1 (aboun all due date of Form 5500 or 5500-EZ for which this extension is requestenths after the normal due date.		•								
You	You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed in C above.										
	to the first transfer to the first transfer to the first fir	\ -	550	0 57							
cases to manifest references to	gnature is not required if you are requesting an extension to file Form 5500	J OF FOR	m bou	U-EZ.							
Part III	Extension of Time to File Form 5330 (see instructions)										
	quest an extension of time until to file Form 5330, a			al due (date of Forn	1 5330.					
a Ent	er the Code section(s) imposing the tax	•	а								
b Ent	er the payment amount attached				•	ь					
	exclse taxes under section 4980 or 4980F of the Code, enter the revision/ ite in detail why you need the extension	amendr	nent d	ate .		С					
				•							
		•									
						•••					
_											
	ities of periury. I declare that to the best of my knowledge and belief the statemen	4	45 *	- fa	and draw and	at and ar	loto and that I				