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).

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

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 01/01/2009 and ending 12/31/2009

A This return/report is for: [X] single-employer plan [ ] multiple-employer plan (not multiemployer) [ ] one-participant plan

B This return/report is for: [ ] first return/report [ ] final return/report
[ ] an amended return/report [ ] short plan year return/report (less than 12 months)

C Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] DFVC program
[ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
ANGEL BRIGHT HOME HEALTH, INC. 401(K) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 05/01/2006

2a Plan sponsor's name and address (employer, if for single-employer plan)
ANGEL BRIGHT HOME HEALTH, INC.

3221 HOLLY RD.
CORPUS CHRISTI, TX 78415

2b Employer Identification Number (EIN) 38-3672737

2c Plan sponsor's telephone number 361-986-1102

2d Business code (see instructions) 621610

3a Plan administrator's name and address (if same as Plan sponsor, enter "Same")
ANGEL BRIGHT HOME HEALTH, INC. 3221 HOLLY RD.
CORPUS CHRISTI, TX 78415

3b Administrator's EIN 38-3672737

3c Administrator's telephone number 361-986-1102

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. Sponsor's name

4b EIN

4c PN

5a Total number of participants at the beginning of the plan year	**5a**	19
b Total number of participants at the end of the plan year	**5b**	23
c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	**5c**	20

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] 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.) [X] Yes [ ] No

If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	110148	204047
b Total plan liabilities	7b	0	
c Net plan assets (subtract line 7b from line 7a)	7c	110148	204047
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from: (1) Employers	8a(1)	9294	
(2) Participants	8a(2)	47353	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	41497	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		98144
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	4041	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	204	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		4245
i Net income (loss) (subtract line 8h from line 8c)	8i		93899
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		50000
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		714
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		1110
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)) ☐ Yes ☒ No

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No

(If "Yes," complete 12a or 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. 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 during the plan year or any prior 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)

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.	09/30/2010	BLANCH FERNANDEZ
	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

SUMMARY ANNUAL REPORT
for
Angel Bright Home Health, Inc. 401(k) Plan

This is a summary of the annual report for Angel Bright Home Health, Inc. 401(k) Plan, 38-3672737/001 for 01/01/2009 through 12/31/2009. The annual report has been filed with the Employee Benefits Security Administration, formerly known as the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Plan expenses were $4,245. These expenses included $204 in administrative expenses, $4,041 in benefits paid to participants and beneficiaries, and $0 in other expenses. A total of 23 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan was $204,047 as of 12/31/2009 compared to $110,148 as of 01/01/2009. During the plan year the plan experienced an increase in its net assets of $93,899. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of $98,144, including employer contributions of $9,294, employee contributions of $47,353 and earnings from investments of $41,497.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. insurance information including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Angel Bright Home Health, Inc., who is Plan Administrator at 3221 Holly Rd., Corpus Christi, TX, 78415, (361) 986-1102. The charge to cover copying cost will be $1.00 for the full annual report, or $0.10 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, if any, or a statement of income and expenses of the plan and accompanying notes, if any, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes, if any, will be included as part of that report. The charge to cover copying costs given above does not include a charge for copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan at 3221 Holly Rd., Corpus Christi, TX, 78415 and at the US Department of Labor in Washington DC, or obtain a copy from the US Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington DC 20210.