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 01/01/2008 and ending 12/31/2008

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;
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFINED BENEFIT PENSION PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/2004

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.

710 BIRCHWOOD AVE., SUITE 101
BELLINGHAM, WA 98225

710 BIRCHWOOD AVE., SUITE 101
BELLINGHAM, WA 98225

2b Employer Identification Number (EIN) 91-1416044

2c Sponsor's telephone number 360-676-0922

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, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/08/2010	DAVID BAKER
	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")
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.

710 BIRCHWOOD AVE., SUITE 101
BELLINGHAM, WA 98225

3b Administrator's EIN
91-1416044

3c Administrator's telephone number
360-676-0922

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**	8
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**	8
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**	8
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	8
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:
1A

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)	X	Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	X	Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	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)	X	**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)	X	**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

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

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 01/01/2008 , and ending 12/31/2008 ,

A Name of plan	**B** Three-digit plan number ▶
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFINE	002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.	91-1416044

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

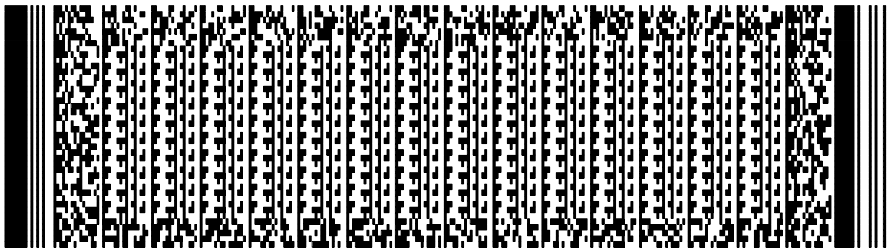
PACIFIC LIFE INSURANCE COMPANY

(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
95-1079000	67466	VF51393600	4	01/01/2008	12/31/2008

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
2782	0



Official Use Only

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

GREENBOOK INSURANCE SERVICES INC.
655 W BROADWAY, SUITE 1050
SAN DIEGO CA 92101

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2283			3

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

GREENBOOK INSURANCE SEVICES I
655 W BROADWAY, SUITE 1050
SAN DIEGO CA 92101

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
499			3

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

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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Official Use Only

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	101265

5 Contracts With Allocated Funds

a State the basis of premium rates ▶

b	Premiums paid to carrier	40547
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

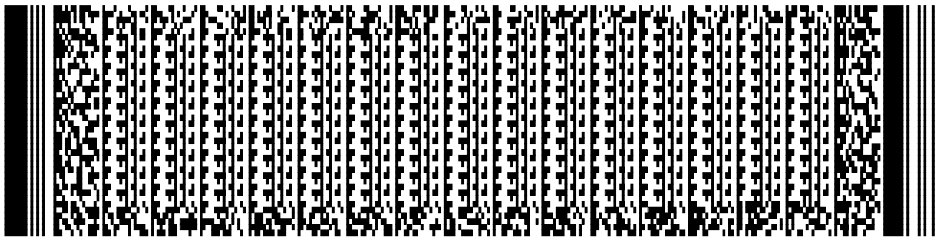
(3) ☐ other (specify) ▶

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		
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		
d	Total of balance and additions (add **b** and **c**(6))		
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		
f	Balance at the end of the current year (subtract **e**(5) from **d**)		



Official Use Only

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 ☐ 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** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ 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))		
b	Benefit charges: (1) Claims paid		
	(2) Increase (decrease) in claim reserves		
	(3) Incurred claims (add (1) and (2))		
	(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		
	(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		
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 ▶

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 01/01/2008 , and ending 12/31/2008 ,

A Name of plan
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFINE

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.

D Employer Identification Number
91-1416044

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

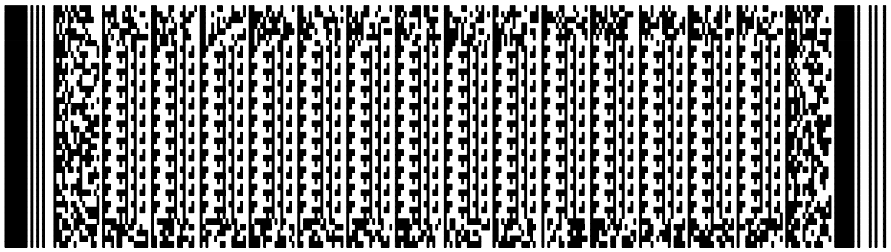
BENEFICIAL LIFE INSURANCE COMPANY

(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
25-1118523	66842	BL2155424	1	01/01/2008	12/31/2008

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
2811	0



Official Use Only

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

BOYCE H GOFF
11100 NE 8TH, SUITE 380
BELLEVUE WA 98004

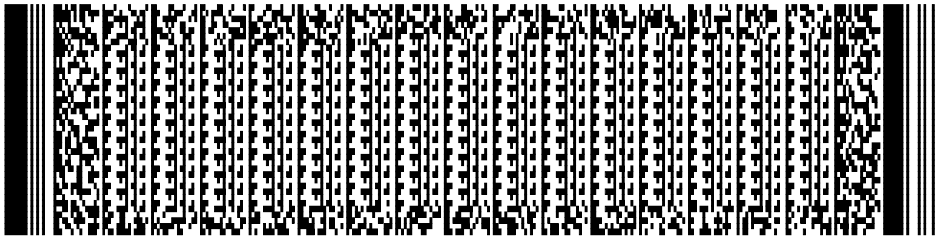
(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2811			3

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

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	



Official Use Only

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	207564

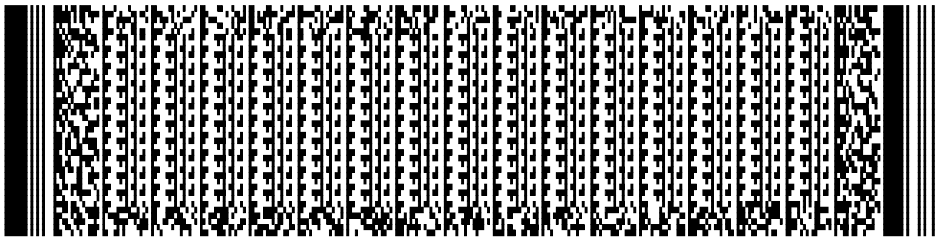
5 Contracts With Allocated Funds

- **a** State the basis of premium rates ▶
- **b** Premiums paid to carrier: 50000
- **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) [X] 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		
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		
d	Total of balance and additions (add **b** and **c**(6))		
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		
f	Balance at the end of the current year (subtract **e**(5) from **d**)		



Official Use Only

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 ☐ 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** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ 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))		
b	Benefit charges: (1) Claims paid		
	(2) Increase (decrease) in claim reserves		
	(3) Incurred claims (add (1) and (2))		
	(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		
	(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		
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 ▶

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 01/01/2008 , and ending 12/31/2008 ,

A Name of plan	**B** Three-digit plan number ▶
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFINE	002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.	91-1416044

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

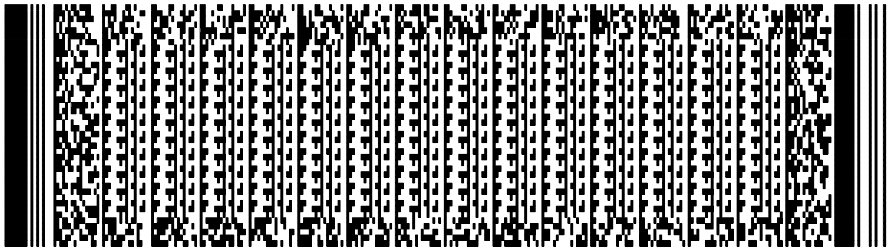
INDIANAPOLIS LIFE INSURANCE

(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
35-0413330	64645	B05020960	2	01/01/2008	12/31/2008

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
3356	0



Official Use Only

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

CHRISTOPHER HAWKINS
550 WEST C STREET, SUITE 1500
SAN DIEGO CA 92101

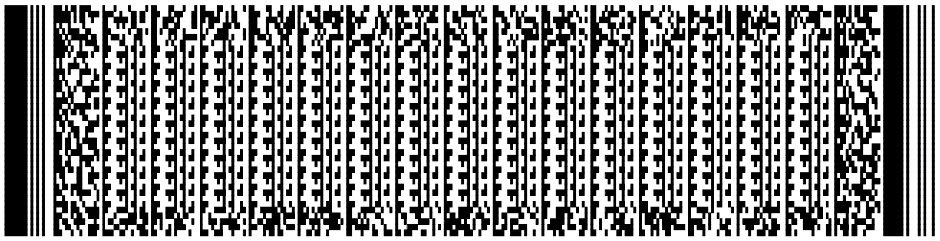
(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3356			3

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

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of commissions paid	Fees paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	



Official Use Only

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	428390

5 Contracts With Allocated Funds

a State the basis of premium rates ▶

b	Premiums paid to carrier	44750
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		
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		
d	Total of balance and additions (add **b** and **c**(6))		
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		
f	Balance at the end of the current year (subtract **e**(5) from **d**)		

0 6 0 8 6 1 0 3 0 O

Official Use Only

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 ☐ 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** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ 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))		
b	Benefit charges: (1) Claims paid		
	(2) Increase (decrease) in claim reserves		
	(3) Incurred claims (add (1) and (2))		
	(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		
	(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		
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 ▶

SCHEDULE I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

Official Use Only

OMB No. 1210-0110

2008

This Form is Open to Public Inspection.

For calendar year 2008 or fiscal plan year beginning 01/01/2008 , and ending 12/31/2008 ,

A Name of plan	**B** Three-digit plan number ▶
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFIN	002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.	91-1416044

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

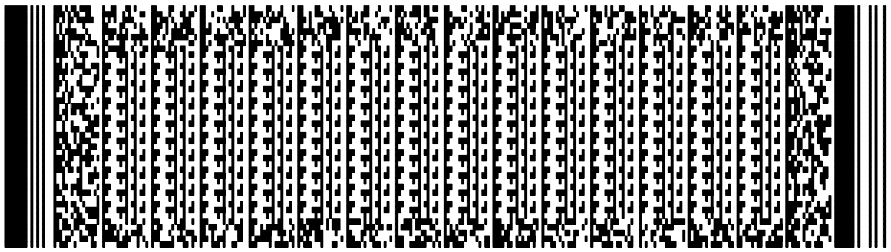
Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

1	**Plan Assets and Liabilities:**		**(a)** Beginning of Year	**(b)** End of Year
a	Total plan assets	**1a**	1648327	1980988
b	Total plan liabilities	**1b**		
c	Net plan assets (subtract line 1b from line 1a)	**1c**	1648327	1980988
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable			
	(1) Employers	**2a(1)**	204954	
	(2) Participants	**2a(2)**		
	(3) Others (including rollovers)	**2a(3)**		
b	Noncash contributions	**2b**		
c	Other income	**2c**	127707	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		332661
e	Benefits paid (including direct rollovers)	**2e**		
f	Corrective distributions (see instructions)	**2f**		
g	Certain deemed distributions of participant loans (see instructions)	**2g**		
h	Other expenses	**2h**		
i	Total expenses (add lines 2e, 2f, 2g, and 2h)	**2i**		
j	Net income (loss) (subtract line 2i from line 2d)	**2j**		332661
k	Transfers to (from) the plan (see instructions)	**2k**		

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	**3a**		X	
b	Employer real property	**3b**		X	



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Official Use Only

			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Transactions During Plan Year

4	During the plan year:		Yes	No	Amount
a	Did the employer fail 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.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e	Was the plan covered by a fidelity bond?	4e	X		200000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ **Yes** ☒ **No** **Amount** _____

5b 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.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

2 0 0 8 6 1 0 2 0 J

Official Use Only

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule 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).

▶ **File as an Attachment to Form 5500.**

OMB No. 1210-0110

2008

This Form is Open to Public Inspection.

For calendar year 2008 or fiscal plan year beginning 01/01/2008 , and ending 12/31/2008 ,

A Name of plan
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFINE

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.

D Employer Identification Number
91-1416044

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . 1 $

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the plan year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). _____ _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? . . . . . ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 7.

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

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6a Enter the minimum required contribution for this plan year . . . . . 6a $

b Enter the amount contributed by the employer to the plan for this plan year . . . . . 6b $

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) . . . . . 6c $

If you completed line 6c, skip lines 7 and 8 and complete line 9.

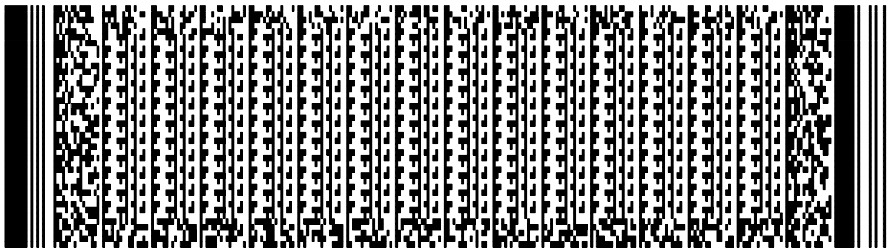
7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? . . ☐ Yes ☐ No ☒ N/A

Part III Amendments

8 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box. (See instructions.) . . . . . ☐ Increase ☐ Decrease ☒ No

Part IV Coverage (See instructions.)

9 Check the box for the test this plan used to satisfy the coverage requirements . . . . ☒ ratio percentage test ☐ average benefit test



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EIN: 91-1416044
PN: 002
Schedule SB, Part V - Summary of Plan Provisions

4CRNR081 09-29-2010

PLAN SPECIFICATIONS
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC., D
BPP

FOR THE PLAN YEAR 01/01/2008 THROUGH 12/31/2008

TYPE OF ENTITY Corporation.

DATES Effective-01/01/2004 Valuation-01/01/2008 Eligibility-01/01/2008 Year-end-12/31/2008
Top Heavy Years - 2004, 2005, 2006, 2007, 2008

ELIGIBILITY Minimum age- 18 Months of service- 5 Maximum age- None
Age at last birthday. Other ages at nearest birthday.
Entry Age For Full Funding Limitation Calculation - as of date of hire.

HOURS REQUIRED FOR
Eligibility - 0 Benefit accrual - 1000 Vesting - 1000

PLAN ENTRY - January 1 or July 1 immediately following satisfaction of eligibility requirements.

New participants are included in current year's valuation.

RETIREMENT NORMAL - First of month coincident with or following attainment of age 62, and completion of 5 years of service, but not later than age 65.

EARLY - No provisions.

AVERAGE COMPENSATION -- (prospective salaries)

FUNDING - Final 3 years.
ACCRUED BENEFIT - Final 3 years.
TOP HEAVY ACCRUED BENEFIT - 5 Highest consecutive top heavy years of service.

PLAN BENEFITS

RETIREMENT-- 8.490% of average monthly compensation multiplied by total years of participation limited to 10 years. Total benefit reduced by 1/10 for each year of participation less than 10 years. Service prior to 01/01/2004 is excluded.

415 Limits - Percent 100.00 Dollar - $15,417

Minimum benefit - None Maximum benefit - None

Maximum 401(a)(17) compensation $230,000

********** TOP HEAVY MINIMUM BENEFITS **********
TEFRA Minimum Benefit: 2.000% of compensation per year plan is top heavy, limited to 10 yrs of participation.
2.000% actuarially adjusted for normal form of benefit.

EIN: 91-1416044
PN: 002
Schedule SB, Part V— Summary of Plan Provisions

4CRNR081 09-29-2010

PLAN SPECIFICATIONS
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC., D
BPP

FOR THE PLAN YEAR 01/01/2008 THROUGH 12/31/2008

NORMAL FORM

Life Annuity.

Assumed form of payment for funding is lump sum equivalent of normal form. Funding Target is greater present value of accrued benefit computed using funding segment rates and 417(e) Applicable Mortality Table or lump sum at normal retirement date of accrued benefit using plan actuarial equivalence discounted using appropriate segment rate. Lump sum on plan actuarial equivalence rates will not exceed 415 maximum allowable distribution, which is least amount computed using a) 5.5% interest and the Applicable Mortality Table or b) plan actuarial equivalence interest and mortality or c) 105% of 417(e) present value (only if not eligible employer under IRC 408(p)).

DEATH BENEFIT

Face amount only.

ACCRUED BENEFIT

Pro-rata based on participation (calculated as of beginning of plan year). Maximum Accrual 10 Years.

Maximum allowable distribution is lump sum equivalent of normal form not to exceed 415 maximum allowable distribution, which is least amount computed using a) 5.5% interest and the Applicable Mortality Table or b) plan actuarial equivalence interest and mortality or c) 105% of 417(e) present value (only if not eligible employer under IRC 408(p)).

TERMINATION BENEFITS

0% first year, 20% each additional year to a maximum of 100% after 6 years. Service is calculated using all years of service except years prior to plan effective date.

CONTRIBUTIONS

EMPLOYEE REQUIRED -- None

EMPLOYEE VOLUNTARY -- None

ASSET VALUATION METHOD

Market value.

INSURANCE

CALCULATION OF FACE AMOUNT:	1.000 times normal retirement benefit.
INSURANCE ISSUE DATE:	01/01/2008
COMPANY NAME:	PG.
POLICY TYPE:	IWL.
PREMIUM MODE:	Annual
WAIVER OF PREMIUM INCLUDED:	No
REPORTABLE INCOME BASED ON:	PS-58 cost
INSURANCE AGE:	Last birthday

EIN: 91-1416044
PN: 007
Schedule SB, Part V - Statement of Actuarial Assumptions / Methods

4CRNR081 09-29-2010

PLAN SPECIFICATIONS
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC., D
BPP

FOR THE PLAN YEAR 01/01/2008 THROUGH 12/31/2008

FUNDING METHOD	As prescribed in IRC Section 430.	
INTEREST RATES	Years 0-5	Segment rate 1 5.310%
	Years 6-20	Segment rate 2 5.900%
	Years over 20	Segment rate 3 6.410%
PRE-RETIREMENT	MORTALITY TABLE --	None.
	TURNOVER/DISABILITY--	None
	SALARY SCALE --	None
	INTEGRATION LVL INCR-	None
	BACKWARD SALARY PROJ.	Based on increase of average earnings
POST-RETIREMENT	MORTALITY TABLE --	2008 Funding Target - Combined - IRC 430(h)(3)(A).
	EXPENSE LOAD --	None
	COST OF LIVING	None
	OPTIONAL FORM	100% of retirees assumed to elect lump sum payment.
	LUMP SUM --	2008 Applicable Mortality Table for IRC 417(e) (Unisex).
		Or
		Actuarial Equivalence

417(e)

PRESENT VALUE OF ACCRUED BENEFIT CALCULATIONS - Greater of 417(e) or Actuarial Equivalence

INTEREST RATES	Years 0-5	Segment rate 1 4.610%
	Years 6-20	Segment rate 2 4.850%
	Years over 20	Segment rate 3 4.960%
	MORTALITY TABLE --	2008 Applicable Mortality Table for IRC 417(e) (Unisex).

Actuarial Equivalence

PRE-RETIREMENT	INTEREST --	5.000%
	MORTALITY TABLE --	None.
POST-RETIREMENT	INTEREST --	5.000%
	MORTALITY TABLE --	2008 Funding Target - Combined - IRC 430(h)(3)(A).

EIN: 91-1416044
PN: 002
Schedule SB, Part V - Statement of Actuarial Assumptions / Methods

4CRNR081 09-29-2010

PLAN SPECIFICATIONS
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC., D
BPP

FOR THE PLAN YEAR 01/01/2008 THROUGH 12/31/2008

ASSUMPTIONS FOR 410(b)/401(a)(4) CALCULATIONS

PRE-RETIREMENT:	INTEREST --	8.500%
POST-RETIREMENT:	INTEREST --	8.500%
	MORTALITY TABLE --	1994 GROUP ANNUITY RESERVING Unisex Proj to 2002 male rates.

PERMISSIVELY AGGREGATED PLANS: Not Tested as Single Plan.

COMPENSATION: Use Current Compensation to calculate the Benefit Accrual Rate (Annual Method).

TESTING AGE: Normal Retirement Age.

EIN: 91-1416044
PN: 002
Fourth Corner Neurosurgical Association, Inc. Defined Benefit Plan
Schedule SB, Line 25 -- Change in Method

The method is changed from the Individual Aggregate Method to the method prescribed in Section 430.

EIN: 91-1416044
PN: 002
Fourth Corner Neurosurgical Association, Inc. Defined Benefit Plan
Schedule SB, Line 22 -- Description of Weighted Average Retirement Age

The retirement age of each participant is age 62 years.

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **Attach to Form 5500 or 5500-EZ if applicable. (See instructions.)**

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 01/01/2008 , and ending 12/31/2008 ,

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
FOURTH CORNER NEUROSURGICAL ASSOCIATION, INC. DEFI

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-EZ
FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S.

D Employer Identification Number (EIN)
91-1416044

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B **F** Prior year plan size: [X] 100 or fewer [ ] 101-500 [ ] More than 500

Part I Basic Information

1 Enter the valuation date: Month 01 Day 01 Year 2008

2	Assets:			
a	Market value		2a	1648327
b	Actuarial value		2b	1648327
3	Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
a	For retired participants and beneficiaries receiving payment	3a	0	0
b	For terminated vested participants	3b	0	0
c	For active participants:			
	(1) Non-vested benefits	3c(1)		581270
	(2) Vested benefits	3c(2)		851722
	(3) Total active	3c(3)	8	1432992
d	Total	3d	8	1432992
4	If the plan is in at-risk status, check the box and complete lines 4a and 4b ▶ [ ]			
a	Funding target disregarding prescribed at-risk assumptions		4a	
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor		4b	
5	Effective interest rate		5	5.93 %
6	Target normal cost		6	406332

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE Garnik M. Akopyan
Signature of actuary

10/6/10
Date

GARNIK M. AKOPYAN
Type or print name of actuary

08-06978
Most recent enrollment number

A.R.I.S., INC.
Firm name

360-756-0776
Telephone number (including area code)

4164 MERIDIAN STREET, SUITE 208
BELLINGHAM WA 98226
Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions. [ ]

Official Use Only

Part II Beginning of year carryover and prefunding balances (See instructions.)

		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	N/A	N/A
8	Portion used to offset prior year's funding requirement (line 35 from prior year)	N/A	N/A
9	Amount remaining (line 7 minus line 8)	4	N/A
10	Interest on line 9 using prior year's actual return of N/A %.	N/A	N/A
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (line 38 from prior year)		N/A
b	Interest on line 11a using prior year's effective rate of N/A %		N/A
c	Total available at beginning of current plan year to add to prefunding balance		N/A
d	Portion of line 11c to be added to prefunding balance		N/A
12	Reduction in balances due to elections or deemed elections	0	N/A
13	Balance at beginning of current year (line 9 + line 10 + line 11d − line 12)	4	N/A

Part III Funding percentages

14	Funding target attainment percentage	14	115.03 %
15	Adjusted funding target attainment percentage	15	115.03 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to offset current year's funding requirement	16	99.99 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and liquidity shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
05/02/2008	4075				
12/11/2008	34731				
12/29/2008	58516				
01/14/2009	5816				
02/05/2009	90000				
09/13/2009	5468				
09/14/2009	6348				
			Totals ▶	18(b) 204954	18(c) 0

19 Discounted employer contributions -- see instructions for small plan with a valuation date after the beginning of the year:

a	Contributions allocated toward unpaid minimum required contribution from prior years	19a	0
b	Contributions made to avoid benefit restrictions adjusted to valuation date	19b	
c	Contributions allocated toward minimum required contribution for current year, adjusted to valuation date	19c	192825

20 Quarterly contributions and liquidity shortfall(s):

a	Did the plan have a "funding shortfall" for the prior year?	☐ Yes	☒ No
b	If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	☐ Yes	☐ No
c	If line 20a is "Yes," see instructions and complete the following table as applicable:		

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Official Use Only

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:

	1st segment:	2nd segment:	3rd segment:	☐ N/A, full yield curve used
a Segment rates:	5.31 %	5.90 %	6.41 %	

b	Applicable month (enter code)	**21b**	0
22	Weighted average retirement age	**22**	62

23 Mortality table(s) (see instructions) ☒ Prescribed -- combined ☐ Prescribed -- separate ☐ Substitute

Part VI Miscellaneous items

24	Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment	☐ Yes	☒ No
25	Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment	☒ Yes	☐ No
26	Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment	☐ Yes	☒ No

27	If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachments	**27**	

Part VII Reconciliation of unpaid minimum required contributions for prior years

28	Unpaid minimum required contribution for all prior years	**28**	0
29	Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	**29**	0
30	Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	**30**	0

Part VIII Minimum required contribution for current year

31	Target normal cost, adjusted, if applicable (see instructions)	**31**	191001

	32 Amortization installments:	Outstanding Balance	Installment
a	Net shortfall amortization installment	0	0
b	Waiver amortization installment	0	0

33	If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	**33**	
34	Total funding requirement before reflecting carryover/prefunding balances (line 31 + line 32a + line 32b - line 33)	**34**	191001

		Carryover balance	Prefunding balance	Total balance
35	Balances used to offset funding requirement	0	0	0

36	Additional cash requirement (line 34 minus line 35)	**36**	191001
37	Contributions allocated toward minimum required contribution for current year, adjusted to valuation date (line 19c)	**37**	192825
38	Interest-adjusted excess contributions for current year (see instructions)	**38**	1824
39	Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	**39**	
40	Unpaid minimum required contribution for all years	**40**	