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

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:
- [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
BANNER PHARMACAPS, INC. 401(K) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 10/01/1990

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

4125 PREMIER DRIVE
HIGH POINT, NC 27265-8144

P.O. BOX 2210
HIGH POINT, NC 27265-8144

2b Employer Identification Number (EIN)
95-2757595

2c Sponsor's telephone number
336-812-8700

2d Business code (see instructions)
325410

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	BRENDA SCALES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with incorrect/unrecognized electronic signature.	10/13/2010	ROBERT GRETTON
	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")
BANNER PHARMACAPS, INC.

4125 PREMIER DRIVE
HIGH POINT, NC 27265-8144

3b Administrator's EIN
95-2757595

3c Administrator's telephone number
336-812-8700

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**	837
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**	556
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	238
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	794
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	794
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	607
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	4
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:
2E 2F 2G 2J 2K 3D 3H

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)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)	X		**H** (Financial Information)
(2)			**I** (Financial Information – Small Plan)
(3)	X	1	**A** (Insurance Information)
(4)	X		**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 (ERISA).

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
BANNER PHARMACAPS, INC. 401(K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
BANNER PHARMACAPS, INC.

D Employer Identification Number (EIN)
95-2757595

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 Information:

(a) Name of insurance carrier
ING LIFE INSURANCE AND ANNUITY 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
71-0294708	86509	PHZ271	794	01/01/2009	12/31/2009

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
5568	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

LPL FINANCIAL CORPORATION
PO BOX 509026
SAN DIEGO, CA 92150

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5568			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	4	5927621
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
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.	6d	

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 ▶ ☐

7 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 ▶ UNALLOCATED ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	5606657
c	Additions: (1) Contributions deposited during the year	7c(1)	533125		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	173276		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)	76625		
	▶ LOAN REPAYMENTS ASSET TRANSFER				
	(6) Total additions			7c(6)	783026
d	Total of balance and additions (add **b** and **c(6)**)			7d	6389683
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	324618		
	(2) Administration charge made by carrier	7e(2)	912		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)	63662		
	▶ LOAN ISSUES				
	(5) Total deductions			7e(5)	389192
f	Balance at the end of the current year (subtract **e(5)** from **d**)			7f	6000491

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

8 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) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
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.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2009** **This Form is Open to Public Inspection.**

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
BANNER PHARMACAPS, INC. 401(K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
BANNER PHARMACAPS, INC.

D Employer Identification Number (EIN)
95-2757595

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

ING LIFE INSURANCE & ANNUITY CO

71-0294708

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
60 62 64 65 72	SERVICE PROVIDER	4350	Yes [X] No [ ]	Yes [X] No [ ]	7483	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

ING FINANCIAL ADVISERS

06-1375177

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
63	INV. PRODUCT PROVIDER	0	Yes [X] No [ ]	Yes [ ] No [X]	5650	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

AMERICAN FUNDS

95-1411037

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 52 63	INV. PRODUCT PROVIDER	0	Yes [X] No [ ]	Yes [ ] No [X]	8199	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

ING PARTNERS

95-4516049

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
28 52	INV. PRODUCT PROVIDER	0	Yes [X] No [ ]	Yes [ ] No [X]	6352	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

LPL FINANCIAL CORPORATION

PO BOX 509026
SAN DIEGO, CA 92150

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
55	BROKER/DEALER	0	Yes [X] No [ ]	Yes [ ] No [X]	11865	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING LIFE INSURANCE & ANNUITY CO	60	1146

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ING FMR DIVERSIFIED MIDCAP 25-6725709	SUB-TA/EXPENSE REIMBURSEMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING LIFE INSURANCE & ANNUITY CO	60 72	1007

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ING OPPENHEIMER GLOBAL PORT 75-3023503	SUB-TA/EXPENSE REIMBURSEMENTS PARTICIPANT HEAD COUNT FEE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING FINANCIAL ADVISERS	63	1290

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN FUNDS GROWTH 52-0792143	12B-1 FEES

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN FUNDS	28 52 63	1577
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN FUNDS AM BALANCED R3 95-1411037	MANAGEMENT FEE OTHER/ADMIN FEES 12B-1 FEE	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN FUNDS	28 52 63	1801
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
WASHINGTON MUTUAL INVESTORS 95-1411037	MANAGEMENT FEE OTHER/ADMIN FEES 12B-1 FEE	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN FUNDS	28 52 63	2425
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN FUNDS GROWTH 52-0792143	MANAGEMENT FEE OTHER/ADMIN FEES 12B-1 FEE	

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN FUNDS	28 52 63	1967

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN FUNDS EUROPACIFIC 95-1411037	MANAGEMENT FEE OTHER/ADMIN FEES 12B-1 FEE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING PARTNERS	28 52 63	1478

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ING OPPENHEIMER GLOBAL PORT 75-3023503	MANAGEMENT FEE OTHER/ADMIN FEES 12B-1 FEE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING PARTNERS	28 52	1228

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ING SOLUTION 2025 PORTFOLIO 47-0951928	MANAGEMENT FEE 12B-1 FEE

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ING PARTNERS	28 52	1109
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
ING SOLUTION 2035 PORTFOLIO 20-2456104	MANAGEMENT FEE OTHER/ADMIN FEES	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN;
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN;
c Position:	
d Address:	**e** Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
BANNER PHARMACAPS, INC. 401(K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
BANNER PHARMACAPS, INC.

D Employer Identification Number (EIN)
95-2757595

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	457575	464672
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	10046353	14688152
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	5606657	6000491
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	16110585	21153315
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	16110585	21153315

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. 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. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	887168	
	(B) Participants	2a(1)(B)	1736150	
	(C) Others (including rollovers)	2a(1)(C)	89479	
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		2712797
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)	31602	
	(F) Other	2b(1)(F)	173276	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		204878
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	243872	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		243872
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		2809778
c Other income	2c		480
d Total income. Add all **income** amounts in column (b) and enter total	2d		5971805
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	924725	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		924725
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	4350	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		4350
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		929075
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		5042730
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [ ] Unqualified (2) [ ] Qualified (3) [X] Disclaimer (4) [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [X] Yes [ ] No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: SMITH LEONARD PLLC (2) EIN: 20-5907591

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. (2) [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

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? Continue to answer "Yes" for any prior year failures until fully corrected. (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 participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		1000000
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 have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

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)

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 section 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

2009

This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
BANNER PHARMACAPS, INC. 401(K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
BANNER PHARMACAPS, INC.

D Employer Identification Number (EIN)
95-2757595

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 year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 71-0294708

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 of 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 8.

5 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 ruling letter granting the waiver. **Date:** 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.

6 **a** 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 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

8 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

9 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. ..... ☐ **Increase** ☐ **Decrease** ☐ **Both** ☐ **No**

Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☐ **No**

11 **a** Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☐ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☐ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☐ **No**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

14 Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	**14a**	
b The plan year immediately preceding the current plan year	**14b**	
c The second preceding plan year	**14c**	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

19 If the total number of participants is 1,000 or more, complete items (a) through (c)

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate item 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

SMITH LEONARD
Accountants & Consultants

Smith Leonard PLLC
4035 Premier Drive, Suite 300
High Point, NC 27265-8132
Phone: 336.883.0181, Fax: 336.841.8764

Independent Auditors' Report

Banner Pharmacaps Inc.
401(k) Plan
High Point, North Carolina

We were engaged to audit the financial statements and supplemental schedule of Banner Pharmacaps Inc. 401(k) Plan as of and for the years ended December 31, 2009 and 2008, as listed in the accompanying table of contents. These financial statements and supplemental schedule are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by ING National Trust, the trustee of the Plan, except for comparing such information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2009 and 2008, that the information provided to the plan administrator by the trustee is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and supplemental schedule taken as a whole. The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Smith Leonard PLLC

October 5, 2010

Banner Pharmacaps Inc.
401(k) Plan

Financial Statements
and Supplemental Schedule

Years Ended December 31, 2009 and 2008

SMITH LEONARD
Accountants & Consultants

Banner Pharmacaps Inc.
401(k) Plan

Financial Statements
and Supplemental Schedule

Years Ended December 31, 2009 and 2008

Banner Pharmacaps Inc.
401(k) Plan

Contents

Independent Auditors' Report **3**

Financial Statements

Statements of Net Assets Available for Benefits – December 31, 2009 and 2008 **4**

Statements of Changes in Net Assets Available for Benefits – Years Ended December 31, 2009 and 2008 **5**

Notes to Financial Statements **6-14**

Supplemental Schedule

Schedule of Assets Held for Investment Purposes at End of Year – December 31, 2009 **15**

SMITH LEONARD
Accountants & Consultants

Smith Leonard PLLC
4035 Premier Drive, Suite 300
High Point, NC 27265-8132
Phone: 336.883.0181, Fax: 336.841.8764

Independent Auditors' Report

Banner Pharmacaps Inc.
401(k) Plan
High Point, North Carolina

We were engaged to audit the financial statements and supplemental schedule of Banner Pharmacaps Inc. 401(k) Plan as of and for the years ended December 31, 2009 and 2008, as listed in the accompanying table of contents. These financial statements and supplemental schedule are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by ING National Trust, the trustee of the Plan, except for comparing such information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2009 and 2008, that the information provided to the plan administrator by the trustee is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and supplemental schedule taken as a whole. The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Smith Leonard PLLC

October 5, 2010

Banner Pharmacaps Inc.
401(k) Plan

Statements of Net Assets Available for Benefits

December 31,	**2009**	2008
Assets		
Investments, at fair value	**$20,615,773**	$15,974,590
Participant loans	**464,672**	457,575
Total investments	**21,080,445**	16,432,165
Receivables:		
Employer contributions	**58,943**	52,406
Net assets available for benefits at fair value	**21,139,388**	16,484,571
Adjustment from fair value to contract value for interest in fully benefit-responsive investment contracts	**72,870**	(321,580)
Net assets available for benefits	**$21,212,258**	$16,162,991

See accompanying independent auditors' report and notes to financial statements.

Banner Pharmacaps Inc.
401(k) Plan

Statements of Changes in Net Assets Available for Benefits

Year ended December 31,	**2009**	2008
Additions (reductions)		
Investment income (loss):		
Net appreciation (depreciation) in current value of investments	**$ 2,810,258**	$ (6,062,457)
Interest and dividends	**448,750**	686,878
Total investment income (loss)	**3,259,008**	(5,375,579)
Employee contributions	**1,825,629**	1,817,221
Employer contributions	**893,705**	792,595
Total additions (reductions)	**5,978,342**	(2,765,763)
Deductions		
Distributions to participants	**924,725**	1,419,296
Administrative fees	**4,350**	3,925
Total deductions	**929,075**	1,423,221
Net increase (decrease)	**5,049,267**	(4,188,984)
Net assets available for benefits – beginning of year	**16,162,991**	20,351,975
Net assets available for benefits – end of year	**$21,212,258**	$16,162,991

See accompanying independent auditors' report and notes to financial statements.

Banner Pharmacaps Inc.
401(k) Plan

Notes to Financial Statements

1. Description of Plan The following is a brief description of the Banner Pharmacaps Inc. 401(k) Plan (the "Plan"). Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General – The Plan is a defined contribution plan covering all eligible employees of Banner Pharmacaps Inc. (the "Company"). An employee is eligible to become a participant of the Plan on the first day of the month after the completion of three months of service and attainment of age 18 years or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Contributions – Eligible participants are entitled to contribute up to 20 percent of their annual compensation to the Plan on both a pre-tax and after-tax ("Roth") basis. The deferral percentage cannot exceed the limitations imposed by the Internal Revenue Code ("IRC"). Participants who have attained age 50 are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or contribution plans. Participants may also contribute up to 100% of bonuses. Company matching contributions for 2009 and 2008 were made under the Safe Harbor Provision, which provides for matching contributions to the account of each eligible participant in an amount equal to the sum of 100% of the amount of the participant's elective deferrals that do not exceed 3% of the participant's compensation plus 50% of the amount of the participant's deferrals between 3% and 5% compensation. The Company may also make discretionary profit sharing contributions to the Plan as determined by its Board of Directors. No discretionary profit sharing contributions were made in 2009 and 2008.

Participant Accounts – Each participant account is credited with the participant's contribution, employer matching contributions, the Company's discretionary contributions, if any, plan earnings, and charged with an allocation of administrative expenses.

1. Description of Plan (Concluded)

Vesting – Plan participants are 100 percent vested in all salary deferrals. Participants are 100 percent vested in all Company Safe Harbor matching contributions. Participants vest in Company profit sharing contributions according to the following schedule:

Completed Years of Service	Vested Percentage
Less than 1 year	50
After 1 year	100

Payment of Benefits – Upon termination of service due to death, disability, retirement or separation, a participant may elect to receive either a partial or lump-sum distribution or installment payments under various options. In-service distributions may be made to participants who have reached age 59½. Withdrawals from the Plan may also be made upon circumstances of financial hardship, in accordance with provisions specified in the Plan.

Participant Loans – Participants may borrow from their fund accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50 percent of their vested account balance. The loans are secured by the balance in the participant's account. Principal and interest is paid ratably through payroll deductions. Participants may only have one outstanding loan at anytime.

Administrative Expenses – The Company absorbs substantially all expenses incidental to the administration of the Plan. Distribution and loan fees are paid from participant accounts.

Forfeitures – Forfeitures of terminated participants' non-vested amounts are used to offset employer matching contributions. No forfeitures were used to offset employer matching contributions in 2009 or 2008. At December 31, 2009, forfeitures available to offset future employer matching contributions were $19,988.

See accompanying independent auditors' report.

2. Summary of Significant Accounting Policies

Basis of Accounting – The accompanying financial statements of the Plan have been prepared on the accrual basis of accounting.

Use of Estimates – The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investment Valuation and Income Recognition – The Plan's investments in mutual funds are stated at fair value, primarily based on quoted market values. The participant loans are stated at their outstanding balances, which approximate fair value. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

Certain investment contracts with ING National Trust ("ING") are included in the financial statements at contract value.

Investment contracts held by a defined-contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined-contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the plan. The Plan invests in investment contracts through ING. The statements of net assets available for benefits present the fair value of the investment in these contracts as well as the adjustment of the investment from fair value to contract values for these investment contracts. The statements of changes in net assets available for benefits are prepared on a contract value basis.

Payment of Benefits – Benefits are recorded when paid.

See accompanying independent auditors' report.

3. Investments

The Plan's investments are held by the trustee. The values of investments that represent 5 percent or more of the Plan's net assets are as follows:

December 31,	**2009**	2008
At contract value:		
Fixed Account	**$ 6,000,491**	$ 5,606,657
At fair value:		
Stock Index Portfolio	**1,587,058**	1,140,626
The Growth Fund of America	**1,550,983**	1,163,257
Fidelity Diversified Mid Cap Portfolio	**1,377,107**	879,421
Washington Mutual Investors	**1,151,737**	926,065
EuroPacific Growth Fund	**1,078,960**	*

* Less than 5%

During 2009 and 2008, the Plan's investments (including gains and losses on investments bought and sold, as well as held during the year) appreciated (depreciated) in value as follows:

Year ended December 31,	**2009**	2008
Mutual funds	**$ 2,810,258**	$ (6,062,457)

See accompanying independent auditors' report.

4. Information Certified by the Plan's Trustee

The plan administrator has elected the method of annual reporting compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the trustee has certified that the following data included in the accompanying financial statements and supplemental schedule is complete and accurate:

December 31,	**2009**	2008
Mutual funds	**$ 14,688,152**	$ 10,046,353
Group annuity contract	**6,000,491**	5,606,657
Participant loans	**464,672**	457,575

Year ended December 31,	**2009**	2008
Net appreciation (depreciation) in fair value of investments	**$ 2,810,258**	$ (6,062,457)
Interest and dividends	**448,750**	686,878

The Plan's independent accountants did not perform auditing procedures with respect to this information, except for comparing such information to the related information included in the financial statements and supplemental schedule.

5. Risk and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risk. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits and the statements of changes in net assets available for benefits.

See accompanying independent auditors' report.

6. Income Tax Status The Plan has adopted a non-standardized plan document sponsored by ING. The Internal Revenue Service has determined and informed ING by a letter dated March 31, 2008, that the Plan and related trust are designed in accordance with applicable sections of the IRC. The Plan has been amended since receiving the determination letter; however, the plan administrator believes that the Plan is designed and is currently being operated in compliance with applicable provisions of the IRC.

7. Plan Termination Although it has not expressed any intent to do so, the Company has the right to discontinue the Plan at any time. In the event the Plan is terminated, each participant becomes fully vested and the net assets of the Plan will be allocated as prescribed by the ERISA.

8. Transactions with Parties-In-Interest Fees paid by the Plan to ING were $4,350 and $3,925 for 2009 and 2008. Plan investments include mutual funds and a group annuity contract managed by ING, which is the trustee as defined by the Plan, and therefore, these transactions qualify as party-in-interest.

9. Investment Contracts The Plan holds certain benefit-responsive investment contracts with ING. ING maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. ING is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but may not be less than 3 percent. Such interest rates are reviewed on a quarterly basis for resetting.

See accompanying independent auditors' report.

9. Investment Contracts (Concluded)

The crediting rates and average yields were as follows:

	2009	2008
Crediting rates	**3.00%**	3.15%
Average yield	**3.00%**	3.15%

Certain events limit the ability of the Plan to transact at contract value with the contract issuer. The plan administrator does not believe that the occurrence of any such event, which would limit the Plan's ability to transact at contract value with the participants, is probable.

10. Fair Value Measurements

The Plan has adopted ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") which establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The three levels of the fair value hierarchy under ASC 820 are as follows:

Basis of Fair Value Measurements

Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities;

Level 2: Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly;

Level 3: Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable.

A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

See accompanying independent auditors' report.

10. Fair Value Measurements (Concluded)

The following table summarizes the investments by level as defined within the fair value hierarchy as of December 31, 2009.

	Investment Assets at Fair Value			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds	$ 14,688,152	$ -	$ -	$ 14,688,152
Group annuity contract	-	5,927,621	-	5,927,621
Participant loans	-	-	464,672	464,672
Total investments at fair value	$ 14,688,152	$ 5,927,621	$ 464,672	$ 21,080,445

The following table summarizes the investments by level as defined within the fair value hierarchy as of December 31, 2008.

	Investment Assets at Fair Value			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds	$ 10,046,353	$ -	$ -	$ 10,046,353
Group annuity contract	-	5,928,237	-	5,928,237
Participant loans	-	-	457,575	457,575
Total investments at fair value	$ 10,046,353	$ 5,928,237	$ 457,575	$ 16,432,165

The following table summarizes the changes in the fair value of the Plan's level 3 investment assets for the year ended December 31, 2009 and 2008.

	Participant Loans	
	2009	2008
Balance, beginning of year	**$ 457,575**	$ 386,953
Net borrowings (repayments)	**7,097**	70,622
Balance, end of year	**$ 464,672**	$ 457,575

See accompanying independent auditors' report.

11. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500:

December 31,	**2009**	2008
Net assets available for benefits per financial statements	**$ 21,212,258**	$ 16,162,991
Contributions receivable	**(58,943)**	(52,406)
Net assets available for benefits per Form 5500	**$ 21,153,315**	$ 16,110,585

The following is a reconciliation of employer contributions per the financial statements to the Form 5500:

Year ended December 31,	**2009**
Employer contributions per the financial statements	**$ 893,705**
Employer contributions receivable, beginning of year	**52,406**
Employer contributions receivable, end of year	**(58,943)**
Employer contributions per the Form 5500	**$ 887,168**

12. Subsequent Events

Management has evaluated events occurring subsequent to the balance sheet date through October 5, 2010, the date that the financial statements were available to be issued determining no events require adjustment to or additional disclosure in the financial statements.

See accompanying independent auditors' report.

Banner Pharmacaps Inc.
401(k) Plan
EIN: 95-2757595
Plan: 001
Schedule of Assets Held for Investment Purposes at End of Year
December 31, 2009

(a)	(b) Identity of Issuer, Borrower, Lessor or Similar Party	(c) Description of Investments including Maturity Date, Rate of Interest, Collateral Par, or Maturity Date	(d) Cost	(e) Current Value
*	ING	Fixed Account	**	$ 6,000,491
*	ING	Stock Index Portfolio	**	1,587,058
	American Funds	The Growth Fund of America	**	1,550,983
*	ING	Fidelity Diversified Mid Cap Portfolio	**	1,377,107
	American Funds	Washington Mutual Investors	**	1,151,737
	American Funds	EuroPacific Growth Fund	**	1,078,960
	American Funds	Balanced Fund	**	1,050,463
*	ING	Oppenheimer Global Portfolio	**	990,595
*	ING	PIMCO Total Return Portfolio	**	862,047
*	ING	Solution 2025 Portfolio	**	702,745
*	ING	T. Rowe Price Growth Equity Portfolio	**	612,772
*	ING	Solution 2035 Portfolio	**	612,032
	American Funds	Fundamental Investors	**	525,339
	Oppenheimer Funds	Main Street Small Cap Fund	**	501,387
	Columbia	Mid Cap Value Fund	**	389,026
	Franklin/Templeton Funds	Eaton Vance Large Cap Value Fund	**	382,166
*	ING	GNMA Income Fund	**	340,567
	Franklin/Templeton Funds	Balance Sheet Investment Fund	**	334,102
*	ING	Solution 2045 Portfolio	**	262,432
*	ING	Solution 2015 Portfolio	**	227,240
*	ING	Solution Income Portfolio	**	68,964
*	ING	Baron Small Cap Growth Portfolio	**	49,867
*	ING	Money Market Fund	**	19,987
*	ING	Columbia Small Cap Value Portfolio	**	10,576
*	Participant Loans	Interest rate ranging from 4.25% to 9.25%	**	464,672
				$ 21,153,315

* - A party-in-interest as defined by ERISA.

** - The cost of participant-directed investments is not required to be disclosed.

See accompanying independent auditors' report.

Banner Pharmacaps Inc.
401(k) Plan
EIN: 95-2757595
Plan: 001
Schedule of Assets Held for Investment Purposes at End of Year
December 31, 2009

(a)	(b) Identity of Issuer, Borrower, Lessor or Similar Party	(c) Description of Investments including Maturity Date, Rate of Interest, Collateral Par, or Maturity Date	(d) Cost	(e) Current Value
*	ING	Fixed Account	**	$ 6,000,491
*	ING	Stock Index Portfolio	**	1,587,058
	American Funds	The Growth Fund of America	**	1,550,983
*	ING	Fidelity Diversified Mid Cap Portfolio	**	1,377,107
	American Funds	Washington Mutual Investors	**	1,151,737
	American Funds	EuroPacific Growth Fund	**	1,078,960
	American Funds	Balanced Fund	**	1,050,463
*	ING	Oppenheimer Global Portfolio	**	990,595
*	ING	PIMCO Total Return Portfolio	**	862,047
*	ING	Solution 2025 Portfolio	**	702,745
*	ING	T. Rowe Price Growth Equity Portfolio	**	612,772
*	ING	Solution 2035 Portfolio	**	612,032
	American Funds	Fundamental Investors	**	525,339
	Oppenheimer Funds	Main Street Small Cap Fund	**	501,387
	Columbia	Mid Cap Value Fund	**	389,026
	Franklin/Templeton Funds	Eaton Vance Large Cap Value Fund	**	382,166
*	ING	GNMA Income Fund	**	340,567
	Franklin/Templeton Funds	Balance Sheet Investment Fund	**	334,102
*	ING	Solution 2045 Portfolio	**	262,432
*	ING	Solution 2015 Portfolio	**	227,240
*	ING	Solution Income Portfolio	**	68,964
*	ING	Baron Small Cap Growth Portfolio	**	49,867
*	ING	Money Market Fund	**	19,987
*	ING	Columbia Small Cap Value Portfolio	**	10,576
*	Participant Loans	Interest rate ranging from 4.25% to 9.25%	**	464,672
				$ 21,153,315

* - A party-in-interest as defined by ERISA.

** - The cost of participant-directed investments is not required to be disclosed.

See accompanying independent auditors' report.