

<b>Form 5500</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Annual Return/Report of Employee Benefit Plan</b>  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).  <b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB Nos. 1210-0110 1210-0089  <div style="text-align: center; font-size: 1.5em; font-weight: bold;">2009</div>  <b>This Form is Open to Public Inspection</b>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2007</u> and ending <u>12/31/2007</u>	
<b>A</b> This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
<b>B</b> This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
<b>C</b> If the plan is a collectively-bargained plan, check here. . . . .	<input type="checkbox"/>
<b>D</b> Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

<b>Part II</b>	<b>Basic Plan Information</b> —enter all requested information	
<b>1a</b> Name of plan <u>RIVER CITIES NEUROLOGY, P.S.C. PROFIT SHARING PLAN</u>	<b>1b</b> Three-digit plan number (PN) ▶	<u>001</u>
<b>2a</b> Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)  <u>RIVER CITIES NEUROLOGY, P.S.C.</u>   <div style="display: flex; justify-content: space-between;"> <div><u>700 SAINT CHRISTOPHER DRIVE XTE 102</u> <u>ASHLAND, KY 41101</u></div> <div><u>700 SAINT CHRISTOPHER DRIVE XTE 102</u> <u>ASHLAND, KY 41101</u></div> </div>		<b>1c</b> Effective date of plan <u>01/01/2003</u>
<b>2b</b> Employer Identification Number (EIN) <u>04-3704709</u>		<b>2c</b> Sponsor's telephone number <u>606-833-0876</u>
<b>2d</b> Business code (see instructions) <u>621111</u>		

**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.

<b>SIGN HERE</b>			
	<b>Signature of plan administrator</b>	<b>Date</b>	<b>Enter name of individual signing as plan administrator</b>
<b>SIGN HERE</b>			
	<b>Signature of employer/plan sponsor</b>	<b>Date</b>	<b>Enter name of individual signing as employer or plan sponsor</b>
<b>SIGN HERE</b>			
	<b>Signature of DFE</b>	<b>Date</b>	<b>Enter name of individual signing as DFE</b>

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

**Form 5500 (2009)**  
**v.092307.1**

<b>3a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same") RIVER CITIES NEUROLOGY, P.S.C.  700 SAINT CHRISTOPHER DRIVE XTE 102 ASHLAND, KY 41101		<b>3b</b> Administrator's EIN 04-3704709
<b>4</b> 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: <b>a</b> Sponsor's name		<b>3c</b> Administrator's telephone number 606-833-0876
<b>5</b> Total number of participants at the beginning of the plan year		<b>5</b>
<b>6</b> Number of participants as of the end of the plan year (welfare plans complete only lines <b>6a</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).		<b>4b</b> EIN
<b>a</b> Active participants.....		<b>4c</b> PN
<b>b</b> Retired or separated participants receiving benefits.....		<b>6a</b>
<b>c</b> Other retired or separated participants entitled to future benefits.....		<b>6b</b>
<b>d</b> Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b> .....		<b>6c</b>
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....		<b>6d</b>
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....		<b>6e</b>
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		<b>6f</b>
<b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....		<b>6g</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....		<b>6h</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:		<b>7</b>

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

<b>9a</b> Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) (3) <input type="checkbox"/> <b>A</b> (Insurance Information) (4) <input type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

Form **5500**Department of the Treasury  
Internal Revenue ServiceDepartment of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**This form is required to be filed under sections 104 and 4065 of the Employee  
Retirement Income Security Act of 1974 (ERISA) and sections 5047(e),  
5057(b), and 5058(a) of the Internal Revenue Code (the Code).▶ Complete all entries in accordance with  
the instructions to the Form 5500.

Official Use Only

OMB Nos. 1510-0110  
1510-0088**2007**This Form is Open to  
Public Inspection.**Annual Report Identification Information**

For the calendar plan year 2007 or fiscal plan year beginning

and ending

- A** This return/report is for: (1) ☐ a multiemployer plan;  
(2) ☒ a single-employer plan (other than a  
multiple-employer plan);

- (3) ☐ a multiple-employer plan; or  
(4) ☐ a DFE (specify) \_\_\_\_\_

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

**C** If the plan is a collectively-bargained plan, check here ☐**D** If filing under an extension of time or the DFE program, check box and attach required information. (see instructions) ☐**Basic Plan Information** — enter all requested information.**1a** Name of plan

RIVER CITIES NEUROLOGY, P.S.C. PROFIT SHARING PLAN

**1b** Three-digit  
plan number (PN) ▶

001

**1c** Effective date of plan (mo., day, yr.)  
01/01/2003**2a** Plan sponsor's name and address (employer, if for a single-employer plan)

(Address should include room or suite no.)

RIVER CITIES NEUROLOGY, P.S.C.

**2b** Employer Identification Number (EIN)  
04-3704709**2c** Sponsor's telephone number  
606-833-0876**2d** Business code (see instructions)  
621111

700 SAINT CHRISTOPHER DRIVE STE 102

ASHLAND

KY

41101

**Caution:** A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and  
attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

Date

PRAMIT BHASIN

Type or print name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

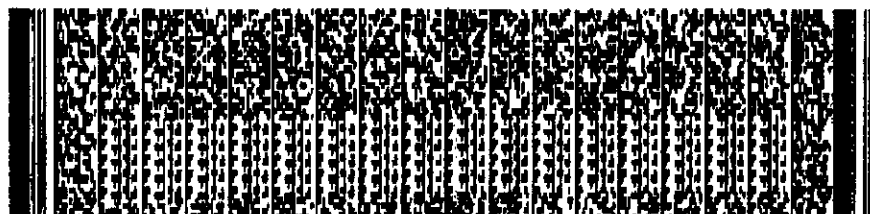
PRAMIT BHASIN

Type or print name of individual signing as employer, plan sponsor or DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address

b EIN

c Telephone number

6 Total number of participants at the beginning of the plan year	6	10
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	8
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	2
d Subtotal. Add lines 7a, 7b, and 7c	7d	10
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	10
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	10
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	2
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	0

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

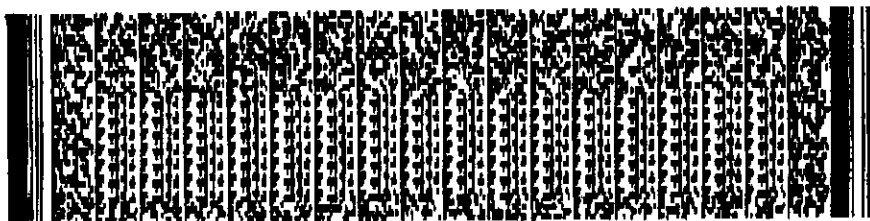
- a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2E 3E 2J ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
- b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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



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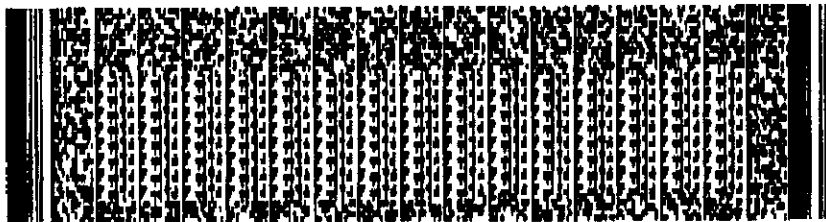
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**10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)****a Pension Benefit Schedules**

- |     |                                     |     |  |
|-----|-------------------------------------|-----|--|
| (1) | <input checked="" type="checkbox"/> | A   | (Retirement Plan Information)              |
| (2) | <input type="checkbox"/>            | B   | (Actuarial Information)                    |
| (3) | <input type="checkbox"/>            | E   | (ESOP Annual Information)                  |
| (4) | <input type="checkbox"/>            | SSA | (Separated Vested Participant Information) |

**b Financial Schedules**

- |     |                                     |   |                                       |
|-----|-------------------------------------|---|---------------------------------------|
| (1) | <input type="checkbox"/>            | H | (Financial Information)               |
| (2) | <input checked="" type="checkbox"/> | I | (Financial Information -- Small Plan) |
| (3) | <input type="checkbox"/>            | A | (Insurance Information)               |
| (4) | <input type="checkbox"/>            | C | (Service Provider Information)        |
| (5) | <input type="checkbox"/>            | D | (DFE/Participating Plan Information)  |
| (6) | <input type="checkbox"/>            | G | (Financial Transaction Schedules)     |



**SCHEDULE I  
(Form 5500)**Department of the Treasury  
Internal Revenue ServiceDepartment 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 8058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1510-0110

**2007**This Form is Open to  
Public Inspection.

For calendar year 2007 or fiscal plan year beginning

and ending

**A** Name of plan

RIVER CITIES NEUROLOGY, P.S.C. PROFIT SHARING PLAN

**B** Three-digit

plan number ▶

001

**C** Plan sponsor's name as shown on line 2a of Form 5500

RIVER CITIES NEUROLOGY, P.S.C.

**D** Employer Identification Number

04-3704709

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.

**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	257132	315090
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a)	1c	257132	315090
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable			
(1) Employers	2a(1)	43670	
(2) Participants	2a(2)	15500	
(3) Others (including rollovers)	2a(3)	0	
b Noncash contributions	2b	0	
c Other income	2c	635	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		59805
e Benefits paid (including direct rollovers)	2e	1847	
f Corrective distributions (see instructions)	2f	0	
g Certain deemed distributions of participant loans (see instructions)	2g	0	
h Other expenses	2h	0	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		1847
j Net income (loss) (subtract line 2i from line 2d)	2j		57958
k Transfers to (from) the plan (see instructions)	2k		0

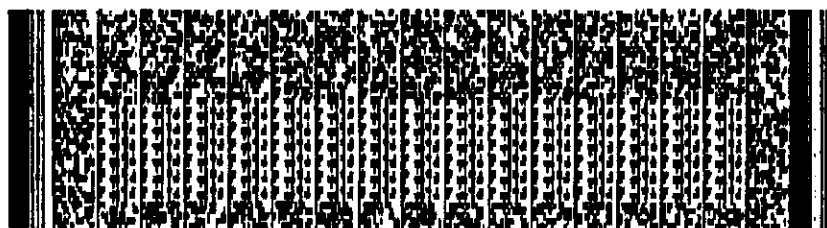
**3** Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the 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		75000
b Employer real property	3b	X	

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

**Part III Transactions During Plan Year**

	Yes	No	Amount
4 During the plan year:			
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.) .....		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 .....		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? .....		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) .....		X	
e Was the plan covered by a fidelity bond? .....	X		75000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....		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? .....		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? .....		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? .....	X		75000
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....		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.) .....	X		

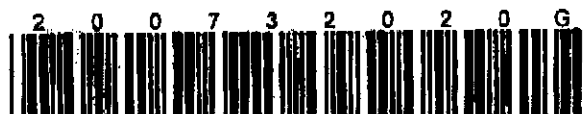
5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year. ☐ Yes ☒ No Amount

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)



**SCHEDULE R  
(Form 5500)**Department of the Treasury  
Internal Revenue ServiceDepartment of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Retirement Plan Information**This schedule is required to be filed under sections 104 and 4085 of the  
Employee Retirement Income Security Act of 1974 (ERISA) and section 8059(a)  
of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

Official Use Only

OMB No. 1510-0110

**2007**This Form is Open to  
Public Inspection.

For calendar year 2007 or fiscal plan year beginning

and ending

**A** Name of plan

RIVER CITIES NEUROLOGY, P.S.C. PROFIT SHARING PLAN

**B** Three-digit  
plan number ▶

001

**C** Plan sponsor's name as shown on line 2a of Form 5500

RIVER CITIES NEUROLOGY, P.S.C.

**D** Employer Identification Number

04-3704709

**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 \$ 0

**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). 04-3704709

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

**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(c)(8) or ERISA section 302(c)(8)? ☐ 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 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 B 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**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**Coverage (See instructions.)****9** Check the box for the test this plan used to satisfy the coverage requirements ☒ the ratio percentage test ☐ average benefit test

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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Schedule R (Form 5500) 2007

