Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

1210-0089

2010

OMB Nos. 1210-0110

This Form is Open to Public Inspection

| Р | ension Benefit Guaranty Corporation | ▶ Complete all entries in accord | dance with | h the instructions to the Form 5500 |)-SF. | | | | | |
|---|---|---|----------------|---------------------------------------|-----------------|---|---------------------|----------------|--|--|
| Pa | art I Annual Report Id | lentification Information | | | | | | | | |
| For | calendar plan year 2010 or fisca | al plan year beginning 01/01/2010 |) | and ending 12 | 2/31/2 | 2010 | | | | |
| Α . | This return/report is for: | single-employer plan | multiple-e | employer plan (not multiemployer) | | one-participa | ant plan | | | |
| В | This return/report is for: | first return/report | final retur | n/report | | _ | | | | |
| | | an amended return/report | short plan | year return/report (less than 12 mor | nths) | | | | | |
| C | Check box if filing under: | Form 5558 | automatic | extension | | DFVC progr | am | | | |
| | | special extension (enter descriptio | n) | | | | | | | |
| Pa | rt II Basic Plan Inforr | nation—enter all requested informa | ation | | | | | | | |
| 1a | Name of plan | | | | 1b | Three-digit | | | | |
| WON | IEN'S HEALTH OF WESTERLY | Y, LLC 401(K) PLAN | | | | plan number | 001 | | | |
| | | | | | 1.0 | (PN) | f l | | | |
| | | | | | 10 | Effective date of 04/01/2 | | | | |
| 2a | Plan sponsor's name and addre | ess (employer, if for single-employer | plan) | | 2b | Employer Ident | | umber | | |
| WON | IENS HEALTH OF WESTERLY | , LLC | | | | (EIN) 05-052 | | | | |
| 45 W | ELLS STREET, SUITE 104 | | | | 2c | Plan sponsor's | telephone 8-0008 | number | | |
| | TERLY, RI 02891 | | | | 2d | Business code | | ictions) | | |
| | | | | | | 62111 | 1 | | | |
| 3a WOM | Plan administrator's name and IENS HEALTH OF WESTERLY | address (if same as Plan sponsor, er | nter "Same | e") UITE 104 | 3b | Administrator's | | | | |
| | ieno nexem or weoreker | WESTERLY, | , - | | 3c | 3c Administrator's telephone numbe | | | | |
| | | | | | | | 8-0008 | | | |
| | • | an sponsor has changed since the las | | port filed for this plan, enter the | 4b EIN | | | | | |
| | name, EIN, and the plan numbe | er from the last return/report. Sponso | rs name | | 4c | PN | | | | |
| 5a | 5a Total number of participants at the beginning of the plan year | | | | 5a | | | | | |
| b Total number of participants at the end of the plan year | | | | | 5b | | | 40 | | |
| | | ith account balances as of the end of | | - | 0.0 | | | | | |
| | | | | ` . | 5c | | Rept | 39 | | |
| | | luring the plan year invested in eligibl | | ' | | | × Ye | s No | | |
| b | | ne annual examination and report of a See instructions on waiver eligibility a | | | | | X Ye | s \square No | | |
| | , | er 6a or 6b, the plan cannot use Fo | | , , , , , , , , , , , , , , , , , , , | | | □ .• | о 🗀 | | |
| Pa | rt III Financial Informa | | | | | | | | | |
| 7 | Plan Assets and Liabilities | | | (a) Beginning of Year | (b) End of Year | | | | | |
| а | Total plan assets | | . 7a | 447476 | i | | | 461401 | | |
| b | Total plan liabilities | | . 7b | | | | | | | |
| С | Net plan assets (subtract line 7 | 7b from line 7a) | 7c | 447476 | i | | | 461401 | | |
| 8 | Income, Expenses, and Transf | fers for this Plan Year | | (a) Amount | | (b) | Total | | | |
| а | Contributions received or received | | 0-(4) | 27319 | | | | | | |
| | | | 8a(1) | 61693 | - | | | | | |
| | , , |) | 8a(2) 8a(3) | | - | | | | | |
| b | ` | | 8b | 60046 | 1 | | | | | |
| C | , | 8a(2), 8a(3), and 8b) | 8c | | | | | 149058 | | |
| d | | rollovers and insurance premiums | . 00 | | | | | | | |
| | to provide benefits) | | 8d | 134553 | | | | | | |
| е | Certain deemed and/or correct | tive distributions (see instructions) | 8e | | 4 | | | | | |
| f | Administrative service provider | rs (salaries, fees, commissions) | 8f | 580 | | | | | | |
| g | Other expenses | | 8g | | | | | 405400 | | |
| h | · | 8e, 8f, and 8g) | | | | | | 135133 | | |
| į | | e 8h from line 8c) | | | | | | 13925 | | |
| j | Transfers to (from) the plan (se | ee instructions) | 8i | | | | | | | |

| | F | Form 5500-SF 2010 Page 2- | | | | |
|------|--|--|----------|----------|----------|-------------------|
| Par | t IV | Plan Characteristics | | | | <u> </u> |
| - | If the | plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Cha | aracteri | stic Co | des in | the instructions: |
| | | 2E 2G 2J 3D 3H | | 0 | | |
| b | If the | plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Cha | racteris | tic Cod | des in t | ne instructions: |
| art | ٧ | Compliance Questions | | | | |
| 0 | Duri | ing the plan year: | | Yes | No | Amount |
| а | | s there a failure to transmit to the plan any participant contributions within the time period described in CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program) | 10a | | X | |
| b | | re there any nonexempt transactions with any party-in-interest? (Do not include transactions reported ine 10a.) | 10b | | Χ | |
| С | Was | s the plan covered by a fidelity bond? | 10c | | X | |
| d | Did t | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | | | |
| е | | re any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, | 10d | | | |
| | insu | rance service or other organization that provides some or all of the benefits under the plan? (See ructions.) | 10e | X | | 2035 |
| f | Has | the plan failed to provide any benefit when due under the plan? | 10f | | X | |
| g | Did t | the plan have any participant loans? (If "Yes," enter amount as of year end.) | 10q | | X | |
| h | | this is an individual account plan, was there a blackout period? (See instructions and 29 CFR | | | X | |
| | | 0.101-3.) | 10h | | ^ | |
| ı | | Oh was answered "Yes," check the box if you either provided the required notice or one of the eptions to providing the notice applied under 29 CFR 2520.101-3 | 10i | | | |
| art | ۷I | Pension Funding Compliance | | | | |
| 11 | | is a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and co | | | | |
| 2 | Is th | nis a defined contribution plan subject to the minimum funding requirements of section 412 of the Coo | de or se | ection 3 | 302 of I | ERISA? Yes 🖺 No |
| | • | es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) | | | | |
| а | | waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instr ting the waiver | | | | |
| lf y | - | completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13 | | | - a, | |
| b | b Enter the minimum required contribution for this plan year | | | | 12b | |
| С | Enter the amount contributed by the employer to the plan for this plan year | | | | 12c | |
| d | | tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the le | | | 12d | |
| е | Will the minimum funding amount reported on line 12d be met by the funding deadline? | | | | | Yes No N/A |
| art | | Plan Terminations and Transfers of Assets | | | | |
| 3a | Has | a resolution to terminate the plan been adopted during the plan year or any prior year? | | | | Yes X No |
| | | es," enter the amount of any plan assets that reverted to the employer this year | | | 13a | |
| b | Were | e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brough | t under | the co | | Yes No |
| С | | ne PBGC?tipe PBGC? | | | | □ 162 □ 140 |

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

13c(2) EIN(s)

13c(3) PN(s)

| SIGN | Filed with authorized/valid electronic signature. | 06/21/2011 | MICHAEL DELMONICO |
|------|---|------------|--|
| HERE | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN | | | |
| HERE | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

2010

1210-0089

OMB Nos. 1210-0110

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

This Form is Open to Public Inspection

| | art I Annual Report Identification Information | | _ | | | | | | |
|---|---|----------------|---------------------------------------|----------|--|--|--|--|--|
| _Fo | calendar plan year 2010 or fiscal plan year beginning | 01/01/ - | 2010 and ending | | 12/31/2010 | | | | |
| Α | This return/report is for: | multiple- | employer plan (not multiemployer) | | one-participant plan | | | | |
| В | This return/report is for: | final retu | rn/report | | | | | | |
| | an amended return/report | short pla | n year return/report (less than 12 mo | nths) | | | | | |
| С | Check box if filing under: Form 5558 | automati | c extension | | DFVC program | | | | |
| | special extension (enter description | on) | | | | | | | |
| Р | art II Basic Plan Information—enter all requested inform | nation | | | Market Ma | | | | |
| 1a | Name of plan | • | | 1b | Three-digit | | | | |
| | WOMEN'S HEALTH OF WESTERLY, LLC 401(K) | PLAN | | | plan number (PN) • 001 | | | | |
| | | | | 1c | Effective date of plan | | | | |
| | | | | | 04/01/2002 | | | | |
| 2a | Plan sponsor's name and address (employer, if for single-employer | r plan) | | 2b | Employer Identification Number | | | | |
| | WOMENS HEALTH OF WESTERLY, LLC | | | 20 | (EIN) 05 - 0520679 2c Plan sponsor's telephone number | | | | |
| | 45 WELLS STREET, SUITE 104 | | | 20 | 401-348-0008 | | | | |
| | WESTERLY RI 02891 | | | 2d | Business code (see instructions) | | | | |
| 2- | | | - 113 | 26 | 621111 Administrator's EIN | | | | |
| эa | Plan administrator's name and address (if same as Plan sponsor, e WOMENS HEALTH OF WESTERLY, LLC | enter Sam | e) | 30 | 05-0520679 | | | | |
| | 45 WELLS STREET, SUITE 104 | | | 3с | Administrator's telephone number | | | | |
| 4 | WESTERLY RI 02891 | | and Slad Sauthia also acts the | A I- | 401-348-0008 | | | | |
| | If the name and/or EIN of the plan sponsor has changed since the la name, EIN, and the plan number from the last return/report. Sponso | | eport filed for this plan, enter the | 4b | EIN | | | | |
| | | | | 4c | PN | | | | |
| 5a | Total number of participants at the beginning of the plan year | | | 5a | 39 | | | | |
| b | b Total number of participants at the end of the plan year | | | 5b | 4 | | | | |
| C Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) | | | 5c | 39 | | | | | |
| 6a | Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) | | | | | | | | |
| b | Are you claiming a waiver of the annual examination and report of | | | | X Yes ∏ No | | | | |
| | under 29 CFR 2520.104-46? (See instructions on waiver eligibility of fyou answered "No" to either 6a or 6b, the plan cannot use Fo | | • | | X Yes No | | | | |
| Pa | rt III Financial Information | 01111 0000 | or and must metera use rorm so | | | | | | |
| 7 | Plan Assets and Liabilities | Paris. | (a) Beginning of Year | | (b) End of Year | | | | |
| а | Total plan assets | . 7a | 44747 | 6 | 461401 | | | | |
| b | Total plan liabilities | 7b | | | | | | | |
| С | Net plan assets (subtract line 7b from line 7a) | 7c | 44747 | 6 | 461401 | | | | |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | | (b) Total | | | | |
| а | Contributions received or receivable from: | 90/4) | 2731 | ا | | | | | |
| | (1) Employers | 8a(1) 8a(2) | 6169 | -1 | | | | | |
| | | | 0109 | 4 | | | | | |
| b | (3) Others (including rollovers) | | 6004 | 6 | | | | | |
| c | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8b 8c | | | 149058 | | | | |
| d | Benefits paid (including direct rollovers and insurance premiums | | | - | | | | | |
| | to provide benefits) | 8d | 13455 | 3 | | | | | |
| е | Certain deemed and/or corrective distributions (see instructions) | 8e | | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | 58 | 0 | | | | | |
| g | Other expenses | 8g | | | | | | | |
| h | , | 8h | | - | 135133 | | | | |
| ĺ | Net income (loss) (subtract line 8h from line 8c) | 8i | | | 13925 | | | | |
| : | Transfers to (from) the plan (see instructions) | 8j | | | | | | | |

| Par | t IV | Plan Characteristics | | | | | | | | | | |
|-------------------------|---|---|--|---|---|---------|-----------|--|----------|--------|-----|--|
| 9a | | plan provides pension benefits, enter the applicable pension feat | ture codes from the | List of Plan Chara | acteris | tic Co | des in | the instruct | tions: | | | |
| b | 2A 2E 2G 2J 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: | | | | | | | | | | | |
| Part | · V | C ompliance Q uestions | i A i A A MALANTA MARANTANA | | | | | 60001413-014-13-13-13-13-13-13-13-13-13-13-13-13-13- | | | | |
| 10 | | ing the plan year: | | | | Y es | No | | A mount | | | |
| а | Was | s there a failure to transmit to the plan any participant contributions CFR 251Q 3-1027 (See instructions and DOL's Voluntary Fiduciar | | | 10a | | Х | | n mount | | | |
| b | | | | actions reported | 10b | | Х | | | | | |
| С | Wa: | s the plan covered by a fidelity bond? | | | 10c | | Х | | | | | |
| d | | the plan have a loss, whether or not reimbursed by the plan's fidel ishonesty? | | | 10d | | Х | | | | | |
| е | Wer | re any fees or commissions paid to any brokers, agents, or other prance service or other organization that provides some or all of the actions.) | ersons by an insur e benefits under the | ance carrier, e plan? (See | 10e | х | | | | 2 | 035 | |
| f | Has | the plan failed to provide any benefit when due under the plan? | | | 10f | | Х | | | | | |
| g | Did 1 | the plan have any participant loans? (If "Yes," enter amount as of y | year end.) | | 10g | | Х | | | | | |
| h | | s is an individual account plan, was there a blackout period? (See Q101-3) | | | 10h | | Х | | | | | |
| i | If 1C exce | th was answered "Yes," check the box if you either provided the repotions to providing the notice applied under 29 CFR 2520 101-3 | equired notice or or | ne of the | 10i | | | | | | | |
| Part | VI | Pension F unding C ompliance | | | | | | | | | | |
| 11 | Is thi 5500 | s a defined benefit plan subject to minimum funding requirements' | ? (If "Yes," see ins | tructions and com | plete S | Sched | ule SE | (Form | Yes | | No | |
| | If a w | res," complete 12a or 12b, 12c, 12d, and 12e below, as applicable. vaiver of the minimum funding standard for a prior year is being an ting the waiver. | nortized in this plar | | | | | | | | _ | |
| - | If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13. b Enter the minimum required contribution for this plan year | | | | | | | | | | | |
| | | r the amount contributed by the employer to the plan for this plan y | | | | | 12c | | | | | |
| c d | Subt | ract the amount in line 12c from the amount in line 12b. Enter the r tive amount) | result (enter a minı | us sign to the left o | ofa | | 12d | | | | | |
| е | Will t | he minimum funding amount reported on line 12d be met by the fu | unding deadline? | | | | | Yes | No | \ \ | I/A | |
| Part | VII | Plan Terminations and Transfers of Assets | | | | | | | **** | | | |
| 13a | Has a | a resolution to terminate the plan been adopted during the plan yea | ar or any prior yea | r? | | | | | Yes | Х | No | |
| | | es," enter the amount of any plan assets that reverted to the emplo | | | | | 13a | | | | | |
| b | of the | e all the plan assets distributed to participants or beneficiaries, tran e PBGC? | | | | | ntrol | | Yes | Х | No | |
| С | C If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.) | | | | | | | | | | | |
| 13c(1) Name of plan(s): | | | | | 13c(2) EIN(s) 1 | | | 13c(3) | PΝ | (s) | | |
| | | | | | | | | | | | | |
| . " | | | | | | | | | | | | |
| Cauti | on: A | penalty for the late or incomplete filing of this return/report w | will be assessed u | ınless reasonahlı | e caus | e is a | establi | shed | <u> </u> | | | |
| Unde SB or | r pena Sche | alties of perjury and other penalties set forth in the instructions, I deduce MB completed and signed by an enrolled actuary, as well as true, correct, and complete. | eclare that I have e | examined this retu | m <i>i</i> rep | ort, in | cluding | j, if applicat | | | | |
| SIGN | IGN NW MICHAEL DE | | | | | ICO | | | | | | |
| HERE | | | | | ndividual signing as plan administrator | | | | | | | |
| SIGN | GN MUNICHAEL D | | | | | ONICO | | | | | | |
| ntKt | HERE Signature of employer/plan sponsor Date / Enter name of in- | | | ndividual signing as employer or plan sponsor | | | | | | | | |

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