## 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

Inspection

This Form is Open to Public

OMB Nos. 1210-0110

1210-0089

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

| P   | art I         | Annual Report Identification Information  | 1               |                                       |        |   |
|-----|---------------|---|-----------------|---------------------------------------|--------|---|
| For | calenda       | ar plan year 2010 or fiscal plan year beginning 01/0  | 1/2010          | and ending 1                          | 2/31/2 | 2010  |
| Α   | This ret      | urn/report is for: Single-employer plan   | multiple-e      | employer plan (not multiemployer)     |        | one-participant plan                              |
|     |               | nis return/report is for:   |                 |                                       |        | _   |
| _   |               | an amended return/report  | Short plai      | n year return/report (less than 12 mo | nths)  |   |
| _   | Chack h       | pox if filing under: Form 5558  | _ <del> </del>  | extension                             | ,      | DFVC program                                      |
| U   | CHECK         | special extension (enter desc   |                 | OCKETIOIOTI                           |        | _ bi vo program                                   |
|     |               |   | ' '             |                                       |        |   |
|     | art II        | Basic Plan Information—enter all requested in   | ntormation      |                                       | 1h     | Throo digit                                       |
|     | Name          | or pian<br>E CARDIOLOGY MEDICAL GROUP PSC 401(K) PLAN   |                 |                                       | מו     | Three-digit plan number                           |
|     | OVILLE        | TO MICE SECTION TO THE PROPERTY OF THE PROPERT  |                 |                                       |        | (PN) • 002  |
|     |               |   |                 |                                       | 1c     | Effective date of plan                            |
|     |               |   |                 |                                       |        | 01/01/1997  |
|     |               | ponsor's name and address (employer, if for single-emp<br>E CARDIOLOGY MEDICAL GROUP PSC  | loyer plan)     |                                       | 2b     | Employer Identification Number                    |
| LOU | OVILLE        | CARDIOLOGT WEDICAL GROOF F3C  |                 |                                       | 2c     | (EIN) 62-1709741  Plan sponsor's telephone number |
|     |               | GE WAY SUITE 60   |                 |                                       |        | 502-893-7710                                      |
| LUU | OVILLE        | E, KY 40207-4660  |                 |                                       | 2d     | Business code (see instructions)                  |
| 20  | Disco         | de l'Arabada  |                 | - 11\                                 | 26     | 621111  |
|     |               |   | RESGE WAY S     | UÍTE 60                               | 30     | Administrator's EIN<br>62-1709741                 |
|     |               | LOUIS   | ILLE, KY 4020   | 7-4660                                | 3c     | Administrator's telephone number                  |
|     |               |   |                 |                                       |        | 502-893-7710                                      |
|     |               | ime and/or EIN of the plan sponsor has changed since t<br>EIN, and the plan number from the last return/report. Sp  |                 | eport filed for this plan, enter the  | 4b     | EIN   |
|     | name, c       | in, and the plan humber from the last return/report. Sp   | onsoi s name    |                                       | 4c     | PN  |
| 5a  | Total r       | number of participants at the beginning of the plan year.   |                 |                                       | 5a     | 69  |
| b   | Total r       | number of participants at the end of the plan year  |                 |                                       | 5b     | 75  |
| С   | Total r       | number of participants with account balances as of the $\epsilon$   | end of the plan | vear (defined benefit plans do not    |        |   |
|     | compl         | ete this item)  |                 |                                       | 5c     | 75  |
|     |               | all of the plan's assets during the plan year invested in $% \left( 1\right) =\left( 1\right) \left( 1\right) \left($ | J               | ,                                     |        | Yes No  |
| b   |               | ou claiming a waiver of the annual examination and repo<br>29 CFR 2520.104-46? (See instructions on waiver eligi  |                 |                                       |        | X Yes ☐ No  |
|     |               | answered "No" to either 6a or 6b, the plan cannot u   | •               | •                                     |        |   |
| Pa  | rt III        | Financial Information   |                 |                                       |        |   |
| 7   | Plan A        | Assets and Liabilities  |                 | (a) Beginning of Year                 |        | (b) End of Year                                   |
| а   | Total p       | olan assets   | 7a              | 4342520                               | )      | 5574012   |
| b   | Total p       | olan liabilities  | 7b              |                                       |        |   |
|     |               | an assets (subtract line 7b from line 7a)   | 7c              | 4342520                               | )      | 5574012   |
| 8   | Incom         | e, Expenses, and Transfers for this Plan Year   |                 | (a) Amount                            |        | (b) Total   |
| а   |               | butions received or receivable from:  |                 | 445522                                |        |   |
|     | <b>(1)</b> Er | mployers  | , ,             |                                       | _      |   |
|     | ` '           | articipants   | · · ·           | 242461                                |        |   |
|     | ` '           | thers (including rollovers)   | ` ′             | F754.24                               | _      |   |
| b   |               | income (loss)   |                 | 575131                                |        | 4002444   |
| C   |               | ncome (add lines 8a(1), 8a(2), 8a(3), and 8b)   |                 |                                       |        | 1263114   |
| d   |               | its paid (including direct rollovers and insurance premiur  |                 | 25980                                 |        |   |
| е   |               | n deemed and/or corrective distributions (see instruction   |                 |                                       |        |   |
| f   |               | istrative service providers (salaries, fees, commissions)   | ,               | 5642                                  | 2      |   |
| g   |               | expenses  |                 |                                       |        |   |
| h   |               | expenses (add lines 8d, 8e, 8f, and 8g)   |                 |                                       |        | 31622   |
| i   |               | come (loss) (subtract line 8h from line 8c)   |                 |                                       |        | 1231492   |
|     |               | rers to (from) the plan (see instructions)  |                 |                                       |        |   |
| J   |               |   |                 |                                       |        |   |

|     | F  | orm 5500-SF 2010 Page <b>2-</b>  |          |          |          |             |        |        |   |
|-----|--|--|----------|----------|----------|-------------|--------|--------|---|
| Par | t IV   | Plan Characteristics   |          |          |          |             |        |        | - |
| Эа  |  | plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Cha $^{2}$ F $^{2}$ G $^{2}$ J $^{2}$ K $^{2}$ T $^{3}$ D   | racteris | stic Co  | des in   | the instruc | tions: |        |   |
| h   |  | plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Char  | acteris  | tic Cod  | des in t | he instruct | ions:  |        |   |
|     |  |  |          |          |          |             |        |        |   |
| art | t V  | Compliance Questions   |          |          |          |             |        |        |   |
| 0   | Durin  | ng the plan year:  |          | Yes      | No       |             | Amount |        |   |
| а   |  | 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   |  | e there any nonexempt transactions with any party-in-interest? (Do not include transactions reported ne 10a.)  | 10b      |          | X        |             |        |        | _ |
| С   | Was  | the plan covered by a fidelity bond?   | 10c      | X        |          |             |        | 400000 |   |
| d   |  | he plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud shonesty?   | 10d      |          | Х        |             |        |        |   |
| е   | insur  | e any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, ance service or other organization that provides some or all of the benefits under the plan? (See actions.) | 10e      |          | X        |             |        |        | _ |
| f   | Has t  | the plan failed to provide any benefit when due under the plan?  | 10f      |          | X        |             |        |        |   |
| g   | Did tl   | he plan have any participant loans? (If "Yes," enter amount as of year end.)   | 10g      | X        |          |             |        | 44008  | - |
| h   |  | s is an individual account plan, was there a blackout period? (See instructions and 29 CFR .101-3.)  | 10h      |          | X        |             |        |        |   |
| i   |  | n was answered "Yes," check the box if you either provided the required notice or one of the ptions to providing the notice applied under 29 CFR 2520.101-3  | 10i      |          |          |             |        |        | Ī |
| art | VI   | Pension Funding Compliance   |          |          |          |             |        |        | - |
| 11  |  | s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor  |          |          |          |             | Yes    | X No   |   |
| 2   | Is thi   | s a defined contribution plan subject to the minimum funding requirements of section 412 of the Cod  | e or se  | ection 3 | 302 of E | ERISA?      | Yes    | X No   |   |
|     |  | es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)   |          |          |          |             |        |        |   |
| а   | If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiverMonth Day Year |  |          |          |          |             |        | 0      |   |
| lf  | •  | ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13   |          |          |          |             |        |        |   |
| b   | Enter  | the minimum required contribution for this plan year   |          |          | 12b      |             |        |        |   |
| С   | Enter the amount contributed by the employer to the plan for this plan year  |  |          |          |          |             |        |        | _ |
| d   |  | act the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the lef tive amount)   |          |          | 12d      |             |        | _      | _ |
| е   | Will th  | ne minimum funding amount reported on line 12d be met by the funding deadline?   |          |          |          | Yes         | No     | N/A    | _ |
| art | VII  | Plan Terminations and Transfers of Assets  |          |          |          |             |        |        | _ |
| 3а  | Has a  | a resolution to terminate the plan been adopted during the plan year or any prior year?  |          |          |          |             | X Yes  | No     | _ |
|     |  |  |          | 1        | 40-      |             |        | 0      |   |

If "Yes," enter the amount of any plan assets that reverted to the employer this year.....

Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....

If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s): 13c(2) EIN(s) 13c(3) PN(s)

Yes No

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

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

| SIGN | Filed with authorized/valid electronic signature. | 07/21/2011 | RUDOLPH F. LICANDRO, M.D.                                    |
|------|---|------------|--|
| 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 |