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

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [X] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 07/01/1970

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

7075 N. SHARON AVENUE
FRESNO, CA 93720

2b Employer Identification Number (EIN) 94-1717441

2c Sponsor's telephone number 559-486-2000

2d Business code (see instructions) 621111

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/12/2011	KRISTIN JONES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/12/2011	KRISTIN JONES
	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")
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

7075 N. SHARON AVENUE
FRESNO, CA 93720

3b Administrator's EIN
94-1717441

3c Administrator's telephone number
559-486-2000

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**	285
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**	212
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	83
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	295
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	295
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	295
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	9
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:
2A 2E 2G 2J 2K 3D

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)	X		**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

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

D Employer Identification Number (EIN)
94-1717441

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
JOHN HANCOCK LIFE INSURANCE COMPANY U.S.A

(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
01-0233346	65838	59675	0	01/01/2010	04/12/2010

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
2859	1562

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
MERRILL LYNCH LIFE AGENCY
SCOTT BELL
5260 N. PALM, #100
FRESNO, CA 93704

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2859	0		7

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ALL VALLEY ADMINISTRATORS, LLC
7525 N. CEDAR AVENUE, SUITE 109
FRESNO, CA 93720

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1534	TPA FEES & COMPENSATION	3

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

BLACKROCK INVESTMENT MANAGEMENT, LL
100 BELLEVUE PARKWAY
WILMINGTON, DE 19809

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
0	28	REDEMPTION FEES	6

(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**	0
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	0

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 ▶

b	Balance at the end of the previous year			**7b**	0
c	Additions: (1) Contributions deposited during the year	**7c(1)**	0		
	(2) Dividends and credits	**7c(2)**	0		
	(3) Interest credited during the year	**7c(3)**	0		
	(4) Transferred from separate account	**7c(4)**	0		
	(5) Other (specify below)	**7c(5)**	0		
	▶				
	(6) Total additions			**7c(6)**	0
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**	0		
	(2) Administration charge made by carrier	**7e(2)**	0		
	(3) Transferred to separate account	**7e(3)**	0		
	(4) Other (specify below)	**7e(4)**	0		
	▶				
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	0

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.**	**2010** **This Form is Open to Public Inspection.**

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

D Employer Identification Number (EIN)
94-1717441

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).. . . . . [X] 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

JOHN HANCOCK LIFE INSURANCE COMPANY
P.O. BOX 600
BUFFALO, NY 14201-0600

01-0233346

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

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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)

JOHN HANCOCK LIFE INSURANCE COMPANY

P.O. BOX 600
BUFFALO, NY 14201-0600

01-0233346

(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?
15 28 59 60 62 63 67	NONE	320	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

CAPITAL RESEARCH AND MANAGEMENT CO.

333 SOUTH HOPE STREET
LOS ANGELES, CA 90071

20-3691658

(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?
64	NONE	10365	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(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 [ ]

(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 ☐

(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 ☐

(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
(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.	

(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 D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan 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.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

D Employer Identification Number (EIN)
94-1717441

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: POOLED SEPARATE ACCOUNT

b Name of sponsor of entity listed in (a): JOHN HANCOCK USA

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
01-0233346-000	P	0

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

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

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

D Employer Identification Number (EIN)
94-1717441

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	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	662604	447467
(2) Participant contributions	1b(2)	0	0
(3) Other	1b(3)	9022	5950
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	892217	1041189
(2) U.S. Government securities	1c(2)	290272	321
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	815765	649279
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	50845	0
(B) Common	1c(4)(B)	2523627	1625957
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	262760	287363
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	3400402	4776524
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	0	0
(15) Other	1c(15)	914296	5686

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)	0	0
	(2) Employer real property	1d(2)	0	0
e	Buildings and other property used in plan operation	1e	0	0
f	Total assets (add all amounts in lines 1a through 1e)	1f	9821810	8839736
	Liabilities			
g	Benefit claims payable	1g	1174	2074
h	Operating payables	1h	16	0
i	Acquisition indebtedness	1i	0	0
j	Other liabilities	1j	0	0
k	Total liabilities (add all amounts in lines 1g through1j)	1k	1190	2074
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	9820620	8837662

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)	447467	
	(B) Participants	2a(1)(B)	452990	
	(C) Others (including rollovers)	2a(1)(C)	0	
	(2) Noncash contributions	2a(2)	0	
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		900457
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	13	
	(B) U.S. Government securities	2b(1)(B)	0	
	(C) Corporate debt instruments	2b(1)(C)	4722	
	(D) Loans (other than to participants)	2b(1)(D)	0	
	(E) Participant loans	2b(1)(E)	13645	
	(F) Other	2b(1)(F)	124571	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		142951
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)	0	
	(B) Common stock	2b(2)(B)	39513	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	0	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		39513
	(3) Rents	2b(3)		0
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	-57946	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		-57946

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	0	
(B) Other	2b(5)(B)	278038	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		278038
(6) Net investment gain (loss) from common/collective trusts	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		152352
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		284319
c Other income	2c		1540
d Total income. Add all **income** amounts in column (b) and enter total	2d		1741224
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	2679056	
(2) To insurance carriers for the provision of benefits	2e(2)	0	
(3) Other	2e(3)	0	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		2679056
f Corrective distributions (see instructions)	2f		0
g Certain deemed distributions of participant loans (see instructions)	2g		0
h Interest expense	2h		0
i Administrative expenses: (1) Professional fees	2i(1)	14374	
(2) Contract administrator fees	2i(2)	0	
(3) Investment advisory and management fees	2i(3)	30282	
(4) Other	2i(4)	470	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		45126
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		2724182
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		-982958
l Transfers of assets:			
(1) To this plan	2l(1)		0
(2) From this plan	2l(2)		0

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)** ☒ Disclaimer **(4)** ☐ Adverse

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

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

(1) Name: MOORE GRIDER & COMPANY **(2)** EIN: 94-2191284

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		91039
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		500000
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	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 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

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
VISION CARE CENTER, A MEDICAL GROUP, INC. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
VISION CARE CENTER, A MEDICAL GROUP, INC. DBA EYE-Q VISION CARE

D Employer Identification Number (EIN)
94-1717441

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** 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):

EIN(s): 94-2858728 01-0233346

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):

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN

FINANCIAL STATEMENTS AND SUPPLEMENTAL DATA

DECEMBER 31, 2010 AND 2009
AND
YEAR ENDED DECEMBER 31, 2010

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN

FINANCIAL STATEMENTS AND SUPPLEMENTAL DATA

DECEMBER 31, 2010 AND 2009
AND
YEAR ENDED DECEMBER 31, 2010

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Moore Grider & Company
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

A Partnership Including Accountancy Corporations

Richard L. Holland, C.P.A.

Thomas L. Bell, C.P.A., Accountancy Corporation

Denise S. Hurst, C.P.A.

Kenneth J. Labendeira, C.P.A., Accountancy Corporation

Pamela J. Gallemore, C.P.A., Accountancy Corporation

Karl L. Noyes, C.P.A., Accountancy Corporation

Cheryl A. Storer, C.P.A., A.P.A.

Kendall K. Wheeler, C.P.A.

Cory J. Bell, C.P.A.

Necia Wollenman, C.P.A.

Rena R. Avedikian, C.P.A.

Kelli D. Steele, C.P.A.

Julie B. Fillmore, C.P.A.

Carrie M. Wiebe, C.P.A.

Nora E. Crow, C.P.A.

Nicholas Medeiros, C.P.A.

Oscar Espinoza, C.P.A.

L. Jerome Moore, C.P.A. Retired

Robert E. Grider, C.P.A. Retired

Plan Administrator
Vision Care Center, A Medical Group, Inc.
401(k) Profit Sharing Plan
Fresno, California

We were engaged to audit the accompanying statements of net assets available for benefits of Vision Care Center, A Medical Group, Inc. 401(k) Profit Sharing Plan as of December 31, 2010 and 2009, and the related statement of changes in net assets available for benefits for the year ended December 31, 2010, and the supplemental schedules as of December 31, 2010. These financial statements and schedules are the responsibility of the plan's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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 3, which was certified by Capital Bank and Trust as agent for American Funds (2010) and John Hancock Life Insurance Company (U.S.A.) (2009), the custodians of the plan, except for comparing the information with the related information included in the financial statements and the supplemental schedules. We have been informed by the plan administrator that the custodians hold the plan's investment assets and execute investment transactions. The plan administrator has obtained a certification from the custodians as of December 31, 2010 and 2009, and for the year ended December 31, 2010, that the information provided to the plan administrator by the custodians 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 schedules taken as a whole. The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the custodians, 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.

Moore Grider & Company

September 26, 2011

325 E. Sierra / Fresno, CA 93710 / 559 440-0700 fax 559 440-0600
www.mooregrider.com

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2010 AND 2009

	2010	2009
ASSETS		
Cash		
Merrill Lynch	$ 4,888	$ 583,224
John Hancock Life Insurance Company (U.S.A.) (unaudited)	0	13,292
Total cash	4,888	596,516
Investments at fair value (Note 3)	8,094,068	8,290,908
Receivables		
Employer contribution	447,467	662,604
Receivable from Citizens Business Bank	125	0
Forfeiture and other receivables	5,823	0
Notes receivable from participants	285,180	265,383
Accrued interest on notes receivable from participants	3,397	0
Accrued interest	2	9,022
Total receivables	741,994	937,009
TOTAL ASSETS	8,840,950	9,824,433
LIABILITIES		
Distribution payable	2,074	1,190
NET ASSETS AVAILABLE FOR BENEFITS	**$ 8,838,876**	**$ 9,823,243**

See Accompanying Notes to Financial Statements

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEAR ENDED DECEMBER 31, 2010

ADDITIONS		
Additions to net assets attributed to:		
Investment income (Note 3):		
Interest and dividends		$ 170,168
Net realized loss on sale of assets		(57,946)
Net appreciation in fair value of investments		714,458
		826,680
Less: investment expense		(30,282)
Net investment income		796,398
Interest income on notes receivable from participants		13,645
Contributions:		
Employer	$ 447,467	
Employee compensation deferrals	452,990	
Total contributions		900,457
TOTAL ADDITIONS		1,710,500
DEDUCTIONS		
Deductions from net assets attributed to:		
Benefits paid to participants	2,680,465	
Administrative fees	14,402	
TOTAL DEDUCTIONS		2,694,867
NET DECREASE		(984,367)
NET ASSETS AVAILABLE FOR BENEFITS, January 1, 2010		9,823,243
NET ASSETS AVAILABLE FOR BENEFITS, December 31, 2010		**$ 8,838,876**

See Accompanying Notes to Financial Statements

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2010 AND 2009

NOTE 1: **DESCRIPTION OF PLAN**

The following description of the Vision Care Center, A Medical Group, Inc., (the Company) 401(k) Profit Sharing Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General – The Plan is a defined contribution plan covering all employees of the company who have three months of service and are age twenty-one or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions – Each year, participants may contribute pretax compensation up to the maximum annual deferral limit. Participants may also contribute amounts representing distributions from other qualified retirement plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan currently offers mutual funds through American Funds and Citizens Trust Managed Accounts as investment options for participants. Starting July 1, 2003, the company adopted a safe harbor plan. The company will make a 3% safe harbor contribution to all eligible employees. The company may also make matching contributions equal to a discretionary percentage of the participant's salary deferral in an amount to be determined by the company's board of directors each year. Additional profit sharing amounts may be contributed at the option of the company's board of directors. Contributions are subject to certain limitations.

Participant accounts – Each participant's account is credited with the participant's contribution and allocations of (a) the company's contribution and forfeitures and, (b) plan earnings, and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting – Participants are vested immediately in their contributions plus actual earnings thereon. They are also immediately vested in any employer safe harbor contributions. Vesting in other company contributions is based on years of continuous service. A participant is 100 percent vested after five (5) years of credited service.

Forfeitures – Forfeitures (participants' allocated interest in plan assets which are not vested because employment is terminated before the vesting period is complete) remain subject to being restored for five years after a participant terminates employment. Forfeiture occurs when the participant withdraws vested amounts or on the valuation date following the participant's five consecutive one-year breaks-in-service. Forfeitures totaled

NOTE 1: **DESCRIPTION OF PLAN** (Continued)

Forfeitures (continued)
$6,375 for the year ended December 31, 2010 and may be used to pay administrative expenses of the Plan or allocated to eligible participants.

Notes receivable from participants – Participants may borrow from their fund accounts. The minimum amount of any loan is $1,000. For participant's having a vested interest in the Plan of $20,000 or less, the maximum amount of any loan is limited to the lesser of 100 percent of the vested interest or $10,000, otherwise, the limit is the lesser of $50,000 or 50 percent of their vested interest. The loans are secured by the balance in the participant's account and bear interest at rates that range from 4.25% to 9.25%, which are commensurate with local prevailing rates. Principal and interest is paid ratably through bi-weekly payroll deductions.

Payment of benefits – On termination of service, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in his or her account, or installments over a period of years certain, selected by the participant that is less than the life of the participant payable on an annual, quarterly or monthly basis. Distributions may also commence upon death, disability, or attainment of normal retirement age.

NOTE 2: **SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

Basis of accounting – The financial statements are prepared using the accrual basis of accounting.

Use of estimates – The preparation of financial statements, in conformity with generally accepted accounting principles, requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Investment valuation and income recognition – Investments are reported at fair value. Fair value is the price that would be received to sell an asset or transfer a liability in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements.

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. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Administrative expenses – All significant expenses of maintaining the Plan, with the exception of contract administration fees, are paid by the company.

NOTE 2: **SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES** (Continued)

Payment of benefits – Benefits are recorded when paid.

NOTE 3: **INVESTMENTS**

Except for the nonreadily marketable investments, at December 31, 2010 and 2009 the Plan's investments were held in pooled separate accounts at Capital Bank and Trust as agent for American Funds (2010) and at John Hancock Life Insurance Company (U.S.A.) (2009), and brokerage accounts at Merrill Lynch (2010 and 2009), and Citizens Trust (2010). Assets held by the custodians, Capital Bank and Trust and John Hancock Life Insurance Company (U.S.A.), are reported based on information certified by the custodians as complete and accurate in accordance with Section 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 accounts are credited with earnings on the underlying investments and charged for plan withdrawals and administrative expenses charged by the investment advisor and custodian.

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See next page for continuation of notes.

NOTE 3: **INVESTMENTS** (Continued)

The fair value of investments at December 31, 2010 and 2009 are summarized as follows:

	2010	2009
INVESTMENTS AT FAIR VALUE AS DETERMINED BY QUOTED MARKET PRICE		
Participant directed funds held at Citizens Trust:		
Money Market	$ 65,915	$ 0
Corporate Bonds	649,279	0
Common Stock	1,625,957	0
	2,341,151	0
Participant directed funds held at Merrill Lynch:		
Money Market	0	295,701
U.S. Government Securities	321	290,272
Corporate Bonds	0	815,765
Preferred Stock	0	50,845
Common Stock	0	2,523,627
	321	3,976,210
Participant directed funds held at American Funds (unaudited):		
Money Market	970,386	0
Mutual Funds	4,776,524	0
	5,746,910	0
Participant directed funds held at John Hancock Life Insurance Company (U.S.A.) (unaudited):		
Mutual Funds	0	3,400,402
Stable Value Fund	0	909,910
	0	4,310,312
NONREADILY MARKETABLE INVESTMENTS		
Other segregated investments:		
Gold Maple Leaf	5,686	4,386
TOTAL INVESTMENTS	**$ 8,094,068**	**$ 8,290,908**

NOTE 3: **INVESTMENTS** (Continued)

Net investment income for the year ended December 31, 2010, is summarized as follows:

NET INVESTMENT INCOME:	
Citizens Trust accounts	$ 299,571
Merrill Lynch accounts	(54,615)
American Funds	397,791
John Hancock Life Insurance Company (U.S.A.)	152,350
Other segregated investments	1,301
	$ 796,398

NOTE 4: **FAIR VALUE MEASUREMENTS**

The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, Fair Value Measurements, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

NOTE 4**:** **FAIR VALUE MEASUREMENTS** (Continued)

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of the observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2010 and 2009.

Common stocks, preferred stock, corporate bonds and U.S. government securities: Valued at the closing price reported on the active market on which the individual securities are traded.

Money market funds: Valued at the net asset value (NAV) of shares held by the Plan at year end.

Mutual funds: Valued at the NAV of shares held by the Plan at year end.

Stable value fund: Valued at the daily NAV published by the Collective Investment Trust (CIT). The value does not reflect the actual market values of CIT's assets.

Gold Maple Leaf: Valued at the closing price in active markets on which ounces of gold are traded.

The methods described above may produce a fair value calculation that may not be indicative of the net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

NOTE 4: **FAIR VALUE MEASUREMENTS** (Continued)

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2010 and 2009:

	Assets at Fair Value as of December 31, 2010			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds:				
Target date funds	$ 4,165,226	$ 0	$ 0	$ 4,165,226
Growth funds	397,914	0	0	397,914
Bond funds	120,037	0	0	120,037
Growth and income funds	46,674	0	0	46,674
Equity and income funds	23,653	0	0	23,653
Balanced funds	23,020	0	0	23,020
Total mutual funds	4,776,524	0	0	4,776,524
Common stocks, corporate bonds and U.S. government securities	2,275,557	0	0	2,275,557
Money market funds	1,036,301	0	0	1,036,301
Gold Maple Leaf	0	5,686	0	5,686
Total assets at fair value	**$ 8,088,382**	**$ 5,686**	**$ 0**	**$ 8,094,068**

	Assets at Fair Value as of December 31, 2009			
	Level 1	**Level 2**	**Level 3**	**Total**
Common stocks, preferred stocks, corporate bonds and U.S. government securities	$ 3,680,509	$ 0	$ 0	$ 3,680,509
Money market funds	295,701	0	0	295,701
Mutual funds	3,400,402	0	0	3,400,402
Stable value fund	0	909,910	0	909,910
Gold Maple Leaf	0	4,386	0	4,386
Total assets at fair value	**$ 7,376,612**	**$ 914,296**	**$ 0**	**$ 8,290,908**

NOTE 5: PLAN TERMINATION

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of plan termination, participants will become 100 percent vested in their employer contributions.

NOTE 6: INCOME TAX STATUS

The Internal Revenue Service ("IRS") ruled on March 31, 2008, that the non-standardized prototype plan document used by the Plan is qualified, in form, under Section 401(a) of the Internal Revenue Code (the "Code") and the underlying trust is, therefore, exempt from federal income tax under Section 501(a) of the Code. The Plan itself has not received a determination letter from the IRS. However, the Plan's management believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code and therefore believes that the Plan is qualified and the related trust is tax-exempt.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the U.S Federal jurisdiction. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2010 and 2009, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The plan administrator believes it is no longer subject to income tax examinations for years prior to 2007.

NOTE 7: RELATED PARTY TRANSACTIONS

The plan investments include shares of mutual funds managed by Capital Bank and Trust as agent for American Funds and John Hancock Life Insurance Company (U.S.A.). Capital Bank and Trust as agent for American Funds and John Hancock Life Insurance Company (U.S.A.) are the custodians as defined by the Plan and, therefore, those transactions qualify as party-in-interest transactions. Fees paid by the Plan for the contract administration to American Funds and John Hancock Life Insurance Company (U.S.A.) amounted to $10,065 and $2,909, respectively.

Participant loans are related party transactions which are exempt from the prohibited transaction rules of ERISA. There were participant loans issued during the year ended December 31, 2010 in the amount of $142,948.

NOTE 8: **RECONCILIATION OF FINANCIAL STATEMENTS TO 5500**

The following is a reconciliation of net assets available for benefits per the financial statements as of December 31, 2010 and 2009:

	2010	2009
Net assets available for benefits per the financial statements	$ 8,838,876	$ 9,823,243
Deemed distributions reported on prior years' Form 5500 that are still plan assets	(1,214)	(2,623)
Net assets available for benefits per the Form 5500	**$ 8,837,662**	**$ 9,820,620**

NOTE 9: **RISKS AND UNCERTAINTIES**

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. 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.

NOTE 10: **SUBSEQUENT EVENTS**

Subsequent events have been evaluated through September 26, 2011 (date financial statements available to be issued) noting no matters requiring disclosure in the financial statements for the year ended December 31, 2010.

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(K) PROFIT SHARING PLAN
SCHEDULE H, LINE 4i
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
ATTACHMENT TO I.R.S. FORM 5500
DECEMBER 31, 2010
EIN 94-1717441-PLAN #001

(a)	(b) Identity of issue, borrower, lesser or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current Value
	INVESTMENTS AT FAIR VALUE			
*	American Funds	American Balanced Fund		$ 23,020
*	American Funds	Capital Income Builder Fund		23,653
*	American Funds	Capital World Bond Fund		17,670
*	American Funds	Capital World Growth & Income Fund		21,099
*	American Funds	Europacific Fund		21,779
*	American Funds	Growth Fund of Amercia		278,500
*	American Funds	High Income Trust Fund		62,579
*	American Funds	Money Market Fund		970,386
*	American Funds	2010 Target Date Fund		155,811
*	American Funds	2015 Target Date Fund		51,801
*	American Funds	2020 Target Date Fund		299,018
*	American Funds	2025 Target Date Fund		172,487
*	American Funds	2030 Target Date Fund		2,069,274
*	American Funds	2035 Target Date Fund		149,453
*	American Funds	2040 Target Date Fund		836,757
*	American Funds	2045Target Date Fund		42,688
*	American Funds	2050 Target Date Fund		386,349
*	American Funds	2055 Target Date Fund		1,588
*	American Funds	Washington Mutual Fund		25,575
	Invesco	Mid Cap Core Equity Fund		25,799
	Invesco	Small Cap Growth Fund		12,800
	Oppenheimer	Gold & Special Minerals Fund		59,036
	PIMCO	Total Return Fund		39,788

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(K) PROFIT SHARING PLAN
SCHEDULE H, LINE 4i (continued)
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
ATTACHMENT TO I.R.S. FORM 5500
DECEMBER 31, 2010
EIN 94-1717441-PLAN #001

(a)	(b) Identity of issue, borrower, lesser or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current Value
	INVESTMENTS AT FAIR VALUE			
	Citizens Trust	Common Stocks		$1,625,957
	Citizens Trust	Corporate Bonds		649,279
	Citizens Trust	Money Market		65,915
	Gold Maple Leaf	4 oz		5,686
	Merrill Lynch Cash	Cash		4,888
	Merrill Lynch Consults Service	U.S. Government Securities		321
*	Participant loans	Interest rates range from 4.25% to 9.25%	0	287,363

VISION CARE CENTER, A MEDICAL GROUP, INC.
401(k) PROFIT SHARING PLAN
SCHEDULE H, LINE 4a
SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS
ATTACHMENT TO I.R.S. FORM 5500
DECEMBER 31, 2010
EIN 94-1717441
PLAN #001

Participant Contributions Transferred Late to Plan	Total that Constitute Nonexempt Prohibited Transactions			
Check here if Late Participant Loan Repayments are included: ___X___	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	Total Fully Corrected Under VFCP and PTE 2002-51
Four payroll dates in 2010 (See Note 1 below)	$ 87,435	$ 0	$ 0	$ 0
Two payroll dates in 2009 (See Note 2 below)	0	3,604	0	0
TOTAL	**$ 87,435**	**$ 3,604**	**$ 0**	**$ 0**

Note 1: The Plan Sponsor deposited the delinquent salary deferrals and loan payments into the Plan during the 2010 plan year. The Plan Sponsor anticipates lost earnings to be calculated and deposited into the Plan by September 15, 2011.

Note 2: The Plan Sponsor deposited the delinquent salary deferrals into the Plan during the 2009 plan year. The Plan Sponsor deposited the lost earnings prior to December 31, 2010.

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

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2010 or fiscal plan year beginning 01/01/2010 **and ending** 12/31/2010

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [x] a single-employer plan;
- [ ] a DFE (specify) _____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [x] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here . . . . . ► [ ]

D Check box if filing under:
- [x] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information --- enter all requested information.

1a Name of plan
Vision Care Center, A Medical Group, Inc. 401(k) Profit Sharing Plan

1b Three-digit plan number (PN) ► 001

1c Effective date of plan 07/01/1970

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

Vision Care Center, A Medical Group, Inc. dba Eye-Q Vision Care

7075 N. Sharon Avenue

US Fresno CA 93720

2b Employer Identification Number (EIN)
94-1717441

2c Sponsor's telephone number
(559) 486-2000

2d Business code (see instructions)
621111

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Kristin Jones	10/7/2011	Kristin Jones
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Scott Bridgeman	10/7/2011	Scott Bridgeman
	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") 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: **a** Sponsor's name	**4b** EIN **4c** PN

5 Total number of participants at the beginning of the plan year	**5**	285
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**	212
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	83
d Subtotal. Add lines **6a, 6b** and **6c**	**6d**	295
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	295
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	295
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	9
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer 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:

2A 2E 2G 2J 2K 3D

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)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	(3) [X] Trust
(4) [ ] General assets of the sponsor	(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	**b** General Schedules		
(1) [X] **R** (Retirement Plan Information)	(1) [X]		**H** (Financial Information)
(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) [ ]		**I** (Financial Information - Small Plan)
	(3) [X]	1	**A** (Insurance Information)
	(4) [X]		**C** (Service Provider Information)
(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) [X]		**D** (DFE/Participating Plan Information)
	(6) [ ]		**G** (Financial Transaction Information)

Schedule H, line 4i
Schedule of Assets (Held At End of Year)

For the plan year beginning 01/01/2010 and ending 12/31/2010

Name of plan

Vision Care Center, A Medical Group, Inc. 401(k) Profit Sharing Plan

Employer Identification Number

94-1717441

Three-digit plan number ► 001

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	AF 2010 TARGET DATE FUND	MUTUAL FUND		155,811
	AF 2015 TARGET DATE FUND	MUTUAL FUND		51,801
	AF 2020 TARGET DATE FUND	MUTUAL FUND		299,018
	AF 2025 TARGET DATE FUND	MUTUAL FUND		172,487
	AF 2030 TARGET DATE FUND	MUTUAL FUND		2,069,274
	AF 2035 TARGET DATE FUND	MUTUAL FUND		149,453
	AF 2040 TARGET DATE FUND	MUTUAL FUND		836,757
	AF 2045 TARGET DATE FUND	MUTUAL FUND		42,688
	AF 2050 TARGET DATE FUND	MUTUAL FUND		386,349
	AF 2055 TARGET DATE FUND	MUTUAL FUND		1,589
	AF AMERICAN BALANCED FUND	MUTUAL FUND		23,020
	AF CAPITAL INCOME BUILDER	MUTUAL FUND		23,653
	AF CAPITAL WORLD BOND FUND	MUTUAL FUND		17,670
	AF CAPITAL WORLD GR & INC	MUTUAL FUND		21,099
	AF EUROPACIFIC GROWTH	MUTUAL FUND		21,779
	AF GROWTH FUND OF AMERICA	MUTUAL FUND		278,500
	AF HIGH INCOME TRUST	MUTUAL FUND		62,579
	AF MONEY MARKET FUND	MUTUAL FUND		970,386
	AF WASHINGTON MUTUAL FUND	MUTUAL FUND		25,575
	INVESCO MID CAP CORE EQUITY	MUTUAL FUND		25,799
	INVESCO SMALL CAP GROWTH FUND	MUTUAL FUND		12,800
	OPPENHEIMER GOLD & SPECIAL MIN	MUTUAL FUND		59,036
	PIMCO TOTAL RETURN	MUTUAL FUND		39,788
	PARTICIPANT LOANS	MUTUAL FUND		287,363

Schedule H, Line 4

Schedule of Delinquent Participant Contributions

For the Plan Year Beginning 01/01/2010 and Ending 12/31/2010
Name of Plan: Vision Care Center, A Medical Group, Inc. 401(k) Profit Sharing Plan
Employer Identification Number: 94-1717441 Three-digit plan number: 001

Participant Contributions Transferred Late to Plan	Total that Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002-51
Check here if Late Participant Loan Repayments are included: X	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
$91,039	$0	$91,039	$0	$0