

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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 2010 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>12/31/2010</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>07/01/1992</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>07/01/1992</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>07/01/1992</u>					
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>ACCELERATED HEALTH SYSTEMS LLC</u> <u>205 W WACKER DR SUITE 1020</u> <u>CHICAGO, IL 60606</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>36-4280414</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>866-249-6230</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>621340</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>36-4280414</u>	2c Sponsor's telephone number <u>866-249-6230</u>	2d Business code (see instructions) <u>621340</u>	
2b Employer Identification Number (EIN) <u>36-4280414</u>					
2c Sponsor's telephone number <u>866-249-6230</u>					
2d Business code (see instructions) <u>621340</u>					

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2011	LISA PRINCE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2011	LISA PRINCE
	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

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

Form 5500 (2010)
v.092307.1

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

ACCELERATED HEALTH SYSTEMS LLC

205 W WACKER DR SUITE 1020
CHICAGO, IL 60606**3b** Administrator's EIN

36-4280414

3c Administrator's telephone number

866-249-6230

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**

1084

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**

1170

b Retired or separated participants receiving benefits.....**6b**

1

c Other retired or separated participants entitled to future benefits.....**6c**

216

d Subtotal. Add lines **6a**, **6b**, and **6c**.....**6d**

1387

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....**6e**

0

f Total. Add lines **6d** and **6e**.....**6f**

1387

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....**6g**

1034

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....**6h**

54

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)**7****8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

2E 2F 2G 2J 3D 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:**9a** Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
- (2) ☐ Code section 412(e)(3) insurance contracts
- (3) ☒ 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) ☒ **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) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information)
- (4) ☒ **C** (Service Provider Information)
- (5) ☒ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500. ACCELERATED HEALTH SYSTEMS LLC	D Employer Identification Number (EIN) 36-4280414

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.
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1 Coverage Information:

(a) Name of insurance carrier
NATIONWIDE LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
31-4156830	66869	GAP-50-BA38		01/01/2010	12/31/2010

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 1753	(b) Total amount of fees paid 6462
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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 PENSION ASSOCIATES INC PO BOX 8100 WAUSAU, WI 54402

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	6462	ADMIN OVERRIDE	5

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid LPL FINANCIAL CORPORATION ATTN CARMELA WILLIAMS 9785 TOWNE CENTRE DR SAN DIEGO, CA 92121

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1753			3

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

LIBERTY LIFE SECURITIES LLC

100 LIBERTY WAY
DOVER, NH 03820

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

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

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

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

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

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

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

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

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

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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6	Contracts With Allocated Funds:		
a	State the basis of premium rates ▶		
b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ <input type="checkbox"/>		
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b	Balance at the end of the previous year	7b	958553
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits	7c(2)	
	(3) Interest credited during the year	7c(3)	
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below)	7c(5)	
	(6) Total additions	7c(6)	0
d	Total of balance and additions (add b and c(6)).	7d	958553
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)	7e(4)	
	(5) Total deductions	7e(5)	0
f	Balance at the end of the current year (subtract e(5) from d)	7f	958553

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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 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
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500. ACCELERATED HEALTH SYSTEMS LLC	D Employer Identification Number (EIN) 36-4280414

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.
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1 Coverage Information:

(a) Name of insurance carrier
NATIONWIDE LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
31-4156830	66869	GAP-54-BA39		01/01/2010	12/31/2010

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 30563	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid LPL FINANCIAL CORPORATION ATTN CARMELA WILLIAMS 9785 TOWNE CENTRE DR SAN DIEGO, CA 92121

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
21094			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid LIBERTY LIFE SECURITIES LLC 100 LIBERTY WAY DOVER, NH 03820

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9469			3

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

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

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

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

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

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

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

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

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

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

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	
5 Current value of plan's interest under this contract in separate accounts at year end	5	
6 Contracts With Allocated Funds:		
a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add b and c(6)).	7d	
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)	7e(4)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract e(5) from d)	7f	

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider 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 ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 ACCELERATED HEALTH SYSTEMS LLC	D Employer Identification Number (EIN) 36-4280414

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 64	N/A		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LINSCO PRIVATE LEDGER CORP

ATTN CARMELA WILLIAMS
9785 TOWNE CENTRE DR
SAN DIEGO, CA 92121-0000

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

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

LIBERTY LIFE SECURITIES LLC

100 LIBERTY WAY
DOVER, NH 03820

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

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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
NATIONWIDE	28	
(d) Enter name and EIN (address) of source of indirect compensation		
ALLIANCE BERNSTEIN FUNDS 1345 AVENUE OF AMERICAS NEW YORK, NY 10105		(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		
NATIONWIDE	28	
(d) Enter name and EIN (address) of source of indirect compensation		
AMERICAN FUND GROUP 333 SOUTH HOPE ST LOS ANGELES, CA 90071-1406		(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		
NATIONWIDE	28	
(d) Enter name and EIN (address) of source of indirect compensation		
DAVIS FUNDS 30 DAN ROAD CANTON, MA 02021-2809		(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 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
NATIONWIDE	28	

(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.
DREYFUS CORPORATION 200 PARK AVE NEW YORK, NY 10166	

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

(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.
GOLDMAN SACHS ASSET MGMT GROUP ONE NEW YORK PLAZA NEW YORK, NY 10004	

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

(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.
INVESCO AIM INVESTMENTS ONE MIDTOWN PLAZA 1360 PEACHTREE ST NE ATLANTA, GA 30309	

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
NATIONWIDE	28	
(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.
JANUS FUNDS 151 DETROIT ST DENVER, CO 80206		
(a) Enter service provider name as it appears on line 2		(b) Service Codes (see instructions)
NATIONWIDE	28	
(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.
NEUBERGER & BERMAN MGMT INC 605 THIRD AVE NEW YORK, NY 10158-3698		
(a) Enter service provider name as it appears on line 2		(b) Service Codes (see instructions)
NATIONWIDE	28	
(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.
OPPENHEIMER FUNDS 498 SEVENTH AVE 10TH FLOOR NEW YORK, NY 10018		

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
NATIONWIDE	28	

(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.
PIMCO FUNDS 840 NEWPORT CENTER DR SUITE 300 NEWPORT BEACH, CA 92660	

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

(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.
VAN KAMPEN ONE PARKVIEW PLAZA OAKBROOK, IL 60181-5555	

(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.

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:

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
ACCELERATED HEALTH SYSTEMS LLC 401K 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
ACCELERATED HEALTH SYSTEMS LLC

D	Employer Identification Number (EIN)
	36-4280414

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: **NATIONWIDE QUALIFIED PLANS VARIABLE**

b Name of sponsor of entity listed in (a): NATIONWIDE LIFE INSURANCE COMPANY

c EIN-PN 31-4156830-009	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 958553
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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)
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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)
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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)
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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)
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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

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 <div style="border: 1px solid black; padding: 5px; font-size: 1.2em; font-weight: bold;">2010</div> This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010		
A Name of plan ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 ACCELERATED HEALTH SYSTEMS LLC	D Employer Identification Number (EIN) 36-4280414	

Part I Asset and Liability Statement			
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities.....	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other.....	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	111815	107320
(9) Value of interest in common/collective trusts.....	1c(9)		
(10) Value of interest in pooled separate accounts.....	1c(10)	13213569	17419717
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	984583	958553
(15) Other	1c(15)		

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	14309967	18485590

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	14309967	18485590
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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)	134488	
(B) Participants	2a(1)(B)	2688010	
(C) Others (including rollovers)	2a(1)(C)	511917	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		3334415
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	4882	
(B) U.S. Government securities	2b(1)(B)	2326	
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	2043	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		9251
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		1862041
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		5205707

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	971271	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		971271
f Corrective distributions (see instructions)	2f		41800
g Certain deemed distributions of participant loans (see instructions).....	2g		8107
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	8906	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		8906
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		1030084

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		4175623
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) ☐ Unqualified (2) ☐ Qualified (3) ☒ 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: KLEIN HALL & ASSOCIATES, LLC

(2) EIN: 37-1437362

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.).....		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		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.)		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.).....		X	
e Was this plan covered by a fidelity bond?.....	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....	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.).....		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?.....		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		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.			

- 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)

<div>SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Retirement Plan Information</div> <div>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).</div> <div>► File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2010</div> <div>This Form is Open to Public Inspection.</div>
For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010		
A Name of plan ACCELERATED HEALTH SYSTEMS LLC 401K PROFIT SHARING PLAN		B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 ACCELERATED HEALTH SYSTEMS LLC		D Employer Identification Number (EIN) 36-4280414
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.....		10
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): 31-4156830		
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 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Both <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11 a Does the ESOP hold any preferred stock? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.		
Schedule R (Form 5500) 2010 v.092308.1		

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): _____

- 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): _____

Accelerated Health Systems, LLC
401(k) Profit Sharing Plan

Audited Financial Statements

December 31, 2010

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
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December 31, 2010

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INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Accelerated Health Systems, LLC
401(k) Profit Sharing Plan
Chicago, Illinois

We were engaged to audit the financial statements of Accelerated Health Systems, LLC 401(k) Profit Sharing Plan as of December 31, 2010 and 2009 and for the year ended December 31, 2010, and the supplemental schedule as of and for the year ended December 31, 2010 as listed in the accompanying index. These financial statements and supplemental schedule are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by Nationwide Financial Services, Inc., the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan sponsor that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of and for the years ended December 31, 2010 and 2009, that the information provided to the plan administrator by the custodian 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 schedule taken as a whole. The form and content of the information included in the financial statements and schedule, other than that derived from the information certified by the custodian, 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.

Klein, Hall & Associates, LLC

Klein, Hall & Associates, LLC
Aurora, Illinois
October 13, 2011

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Statement of Net Assets Available for Benefits
December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
ASSETS		
Participant-directed investments, at fair value	<u>\$ 18,378,270</u>	<u>\$ 14,198,152</u>
Receivables		
Notes receivable from participants	107,320	111,815
Participant contributions	69	57,337
Employer contributions	<u>150,434</u>	<u>134,488</u>
Total Receivables	<u>257,823</u>	<u>303,640</u>
Total Assets	18,636,093	14,501,792
LIABILITIES	<u>-</u>	<u>-</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 18,636,093</u></u>	<u><u>\$ 14,501,792</u></u>

See accompanying notes.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Statement of Changes in Net Assets Available for Benefits
For the Year Ended December 31, 2010

ADDITIONS TO NET ASSETS ATTRIBUTED TO:

Investment income	
Net appreciation in fair value of investments	\$ 1,869,249
Interest income from notes receivable from participants	2,043
Contributions	
Employer contributions	150,434
Participant contributions	2,630,742
Merger of plan assets	448,209
Participant rollovers	63,708
	3,293,093
Total Additions	5,164,385

DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:

Benefits paid to participants	1,021,178
Administrative fee	8,906
Total Deductions	1,030,084
Net Increase	4,134,301

NET ASSETS AVAILABLE FOR BENEFITS:

Beginning of year	14,501,792
End of year	\$ 18,636,093

See accompanying notes.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements
December 31, 2010 and 2009

NOTE 1 – DESCRIPTION OF PLAN

The following description of Accelerated Health Systems, LLC 401(k) Profit Sharing Plan (the “Plan”) provides only general information. Participants should refer to the Plan Agreement for a complete description.

General

The Plan is a defined contribution Plan maintained on a 12-month plan year, which begins on January 1 and ends on December 31. The Plan was established by Accelerated Rehabilitation Centers and Accelerated Health Systems and their Affiliates 401(k) Profit Sharing Plan’s sponsor, on July 1, 1980 and covers all employees of the company. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Affiliated companies included in the Plan are as follows:

Accelerated Rehabilitation Centers, Ltd.
Accelerated Health Systems, LLC
Accelerated of Iowa, LLC
Olympia Fields Physical Therapy, P.C.
Farmington Physical Therapy, Inc.
Eastern Iowa Therapeutics, P.C.
Great River Therapeutics, P.C.
Accelerated Health Systems of Phoenix, LLC
Gary Gray Physical Therapy Clinic, Inc.
Rebound Physical Therapy, PC

Effective January 1, 2009, as amendment of the Plan was adopted to reflect certain provisions of the Internal Revenue Code (Pension Protection Act, HEART Act, and WRAERA).

Eligibility

An employee of Accelerated Rehabilitation Centers, Ltd and Affiliates (the “company”) is eligible to participate in the 401k (elective contributions) on the first day of the month following the hire date and is eligible to participate in the profit sharing plan with one year of service, at least 1,000 hours worked during that plan year, age 21 or older, and employed on the last day of the Plan year.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

Participant Contributions

An eligible employee may elect to contribute up to a maximum of 75% of compensation, not to exceed current IRS regulations. These contributions are not subject to federal income tax until withdrawn. Eligible employees may also contribute, with the consent of the plan administrator, amounts representing distributions from other qualified defined benefit or defined contribution plans, including ROTH contributions. Participants direct the investment of their contributions into various investment options offered by the Plan. The participants are able to change their investment options on a daily basis.

Employer Contributions

The Plan does not provide for employer matching contributions. The employer may make a discretionary contribution, which is not limited to its current or accumulated net profit, for eligible participants. The discretionary contribution is equivalent to an amount not to exceed 5.7% of a participant's compensation plus their excess compensation.

The employer discretionary contributions for the years ended December 31, 2010 and 2009 was 0.4% of compensation, which amounted to \$150,434 and \$134,488, respectively.

Participant Accounts

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

Vesting

Participants are 100% vested in their employee 401(k) deferral. Participants are also fully vested upon their early or normal retirement date.

Participants vest in their employer discretionary contribution accounts in accordance with the following table:

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

Completed Years of Service	Percentage of Account Balance Vested
1	20 %
2	40
3	60
4	80
5	100

Forfeitures

Any funds from forfeited non-vested accounts are used to add to the future employer contributions. The total amount of forfeitures for the years ended December 31, 2010 and 2009 amounted to \$18,014 and \$18,202, respectively. During the year ended December 31, 2010, forfeitures of \$19,336 were reallocated to participants.

Notes Receivable from Participants

Participants may borrow from their salary deferral and rollover accounts a minimum of \$500 up to a maximum equal to the lesser of \$50,000 or 50% of their vested account balance, whichever is less. Loan terms range from one to five years. Loans for the purchase of a principal residence can be paid over a reasonable period of time, which may exceed five years. The loans are secured by the balance in the participant's account and generally bear interest commensurate with local prevailing rates as determined by the plan administrator. A participant may have no more than 2 outstanding loans at one time. Principal and interest is paid ratably through monthly payroll deductions. The balance of participant loans at December 31, 2010 and 2009 was \$107,320 and \$111,815, respectively.

Benefits

Upon death, permanent total disability or termination of service, a participant may elect to receive the value of the participant's vested interest in his or her account. If the vested account balance does not exceed \$5,000, then the balance may only be distributed in the form of a lump sum payment. If the vested account balance exceeds \$5,000, then the participant may elect to receive either a lump sum payment or partial withdrawals of at least \$1,000.

Administrative Expenses

All administrative costs, charges and expenses are paid by the Plan to the extent not paid by the Company.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are described below and have been consistently applied.

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting.

Notes Receivable from Participants

Loans to participants are reported at their unpaid principal balances plus any accrued but unpaid interest.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value. Fair values are determined by the custodian based upon quoted market prices as of December 31, 2010 and 2009, and along with cost data, are summarized from the verified annual report of the custodian, which included the following:

- Current year-end values of each class of investment;
- Changes for the year in the fair value of each class of investment;
- Receipts;
- Disbursements;
- Realized gains and losses

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.

Payment of Benefits

Benefits are recorded when paid.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of additions to and deductions from net assets available for benefits during the reporting period. Actual results could differ from those estimates.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

Subsequent Events

Subsequent events were evaluated through October 6, 2011, which is the date the financial statements were available to be issued.

Change in Accounting Principles

The Plan adopted a new Accounting Standard, *Reporting Loans to Participants by Defined Contribution Pension Plans*, which provides clarification of how loans to participants should be classified and measured by defined contribution pension benefit plans. This guidance requires that loans to participants be reported as notes receivable from participants in the statement of net assets available for benefits and be measured at their unpaid principal plus only accrued but unpaid interest. The plan adopted this Standard in its December 31, 2010 financial statements and has reclassified participant loans of \$107,318 and \$111,815 from participant directed investments to notes receivable from participants as of December 31, 2010 and 2009, respectively.

The Plan also reclassified interest income from participant loans of \$2,043 from participants for the years ended December 31, 2010. Net assets of the Plan were not affected by the adoption of this Standard.

NOTE 3 – INFORMATION PREPARED AND CERTIFIED BY TRUSTEE

The following information included in the accompanying financial statements and supplemental schedules was obtained from data that has been prepared and certified to as complete and accurate by the trustee.

	2010	2009
Investments, at fair value	\$18,378,270	\$14,198,152
Notes receivable from participants	107,320	111,815
Investment income	1,869,249	2,807,893
Interest income from notes receivable from participants	2,043	1,525

NOTE 4 – INVESTMENTS

The following presents the fair value of investments that represent 5% or more of the Plan's net assets as of December 31:

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

	2010	2009
AIM Dynamics Fund	\$ 913,193	\$ 793,962
NW S&P 500 Fund	1,124,587	974,298
Janus Advanced Balance Fund	938,260	816,905
Janus Twenty Fund	1,705,157	1,612,336
NEU Berg Genesis Fund	1,707,859	1,296,371
Pimco Total Return Fund	1,380,458	1,136,802
Fixed Fund	958,553	984,583
Allber International Val K	1,060,746	1,018,356
American Funds Growth Fund	1,038,816	811,016

For the year ended December 31, 2010, the Plan's investments (including investments bought, sold, and held during the year) appreciated in value as follows:

Pooled separate accounts	\$1,866,624
Guaranteed investment contract	<u>2,625</u>
Total	<u>\$1,869,249</u>

The Plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, Nationwide Financial Services, Inc., the custodian of the Plan, has certified to the completeness and accuracy of net assets available for benefits as of December 31, 2010, the schedule of assets held for investment purposes as of December 31, 2010 and the related investment activity reflected in the statement of changes in net assets available for benefits for the period January 1, 2010 through December 31, 2010.

NOTE 5 – FAIR VALUE MEASUREMENTS

FASB ASC 820, Fair Value Measurement and Disclosures, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes that 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 as follows:

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

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

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 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 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, corporate bonds and U.S. Government securities: Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds: Valued at the net asset value (NAV) of shares held by the plan at year-end.

Pooled separate accounts: valued at the NAV of shares held by the Plan at year-end as provided by the administrator of the fund. The NAV is based on the value of the underlying assets owned by the fund, minus its liabilities, and then divided by the number of units outstanding. The NAV's unit price is quoted on a private market that is not active; however, the unit price is based on the underlying investments which are traded on an active market.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

Guaranteed investment contract: Valued at fair value by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the creditworthiness of the issuer.

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

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

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Pooled separate accounts	\$ -	\$ 17,419,717	\$ -	\$ 17,419,717
Guaranteed investment contract	-	-	958,553	958,553
	<u>\$ -</u>	<u>\$ 17,419,717</u>	<u>\$ 958,553</u>	<u>\$ 18,378,270</u>

Assets at Fair Value as of December 31, 2009

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Pooled separate accounts	\$ -	\$ 13,213,569	\$ -	\$ 13,213,569
Guaranteed investment contract	-	-	984,583	984,583
	<u>\$ -</u>	<u>\$ 13,213,569</u>	<u>\$ 984,583</u>	<u>\$ 14,198,152</u>

Fair Value Measurements Using Significant Unobservable Inputs (Level 3)

	<u>Investment Contract</u>
<u>December 31, 2010</u>	
Beginning balance	\$ 984,583
Total gains or losses (realized and unrealized included in changes in net assets available for benefits)	2,625
Purchases, sales, issuances, and settlements (net)	(28,655)
Ending balance	<u>\$ 958,553</u>

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

	<u>Investment Contract</u>
<u>December 31, 2009</u>	
Beginning balance	\$ 994,147
Total gains or losses (realized and unrealized included in changes in net assets available for benefits	4,194
Purchases, sales, issuances, and settlements (net)	<u>(13,578)</u>
Ending balance	<u>\$ 984,583</u>

Gains and losses (realized and unrealized) included in changes in net assets available for benefits for the year ended December 31, 2010 are reported in net appreciation in fair value of investments.

NOTE 6 – CONTRACT WITH INSURANCE COMPANY

In 1999, the Plan entered into a fully guaranteed investment contract with Nationwide Life Insurance Company. Nationwide maintains the contributions in a pooled account.

The account is credited with earnings on the underlying investments (Guaranteed Fixed Fund) and charged with plan withdrawals and administrative expenses charged by Nationwide.

The contract is included in the financial statements at fair market value, which represents contributions made under the contract, plus earnings, less Plan withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at fair market value.

The fair value of the investment contract approximates contract value as of December 31, 2009. There are no allowances against the contract value for credit risk of the contract issuer or otherwise. The average yield and crediting interest rate was approximately 0.28% and 0.43% for 2010 and 2009, respectively.

NOTE 7 – TERMINATION

Although it has not expressed any intent to do so, the company has the right to discontinue contributions and to terminate the Plan at any time, subject to the provisions of ERISA. In the event of plan terminations, participants will become 100% vested in all of their account balances.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

NOTE 8 – REFUND OF EXCESS CONTRIBUTION

The Plan did not pass the Average Deferral Percentage Test for the year ended December 31, 2009. As a result, a portion of the contributions made by “highly compensated employees” has to be refunded to them in order for the Plan to maintain its status with the Internal Revenue Service as a qualified retirement plan. Earnings and losses on the excess contributions have also been included / deducted in the refund.

NOTE 9 – PARTY-IN-INTEREST TRANSACTIONS

Certain Plan investments are mutual funds managed or administered by Nationwide Life Insurance Company, the custodian of the Plan, and therefore, these transactions qualify as party-in-interest transactions.

NOTE 10 – TAX STATUS

The Plan has adopted a prototype non-standardized 401(k) profit sharing plan and Trust created by Pension Associates, Inc. (“Pension Associates”).

The Internal Revenue Service has determined and informed the Company by a letter dated May 15, 2001, that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, the Plan administrator and the Plan’s tax counsel believe that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

NOTE 11 – RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2010 and 2009:

	<u>2009</u>	<u>2010</u>
Net assets available for benefits per financial statements	\$ 14,501,792	\$ 18,636,093
Less: Participant contributions receivable	(57,337)	(69)
Employer contributions receivable	(134,488)	(150,434)
Net assets available for benefits per Form 5500	<u>\$ 14,309,967</u>	<u>\$18,485,590</u>

The following is a reconciliation of net increase in net assets per the financial statements to the Form 5500 for the year ended December 31, 2010:

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Notes to Financial Statements (Continued)
December 31, 2010 and 2009

Net increase in net assets per financial statements	\$ 4,134,301
Add: Participant discretionary contributions	
receivable – prior year	57,337
Employer discretionary contributions	
receivable – prior year	134,488
Less: Participant discretionary contributions	
receivable – current year	(69)
Employer discretionary contributions	
receivable – current year	(150,434)
Net increase in net assets per Form 5500	<u>\$ 4,175,623</u>

NOTE 12 – RISK 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 statement of net assets available for benefits.

NOTE 13 – PLAN MERGER

During December 2009, Accelerated Health Systems, LLC (AHS) acquired Occu-Sport Services, Inc., Occu-Sport Physical Therapy of St. Charles, P.C. and Occu-Sport Physical Therapy of Algonquin, P.C. As a result, during January 2009, the net assets of the Occu-Sport Services, Inc. 401(k) Plan, Occu-Sport Physical Therapy of St. Charles, P.C. 401(k) Trust and Occu-Sport Physical Therapy of Algonquin, P.C. 401(k) Trust were transferred into the AHS Plan. The participants of the Occu-Sport Plans became eligible to participate in the AHS Plan effective January 2009. The net assets of the Occu-Sport Plans were transferred in the AHS Plan during first quarter of 2009.

On December 31, 2009, Therapy Services of Iowa 401(k) Profit-Sharing Plan merged into the Plan. This merger took place in April 2010. The ROTH accounts that were transferred to the Plans for the affected participants will continue to be maintained in the Plan. Total assets transferred into the Plan were \$448,209.

ACCELERATED HEALTH SYSTEMS, LLC
401(K) PROFIT SHARING PLAN
Schedule of Assets Held at End of Year -Schedule H, Line 4i
December 31, 2010

E.I.N. 36-4280414 Plan Number 001

(a)	Identity of Issuer Borrower, Lessor or Similar Party (b)	Description of Investment, Rate of Interest (c)	Cost (d)	Current Value (e)
	* Janus Twenty Fund	Pooled separate accounts	N/A	\$ 1,705,157
	* NEU Berg Genesis Fund Tc	Pooled separate accounts	N/A	1,707,859
	* Fixed Fund	Investment contract	N/A	958,553
	* NW S&P 500 Index Fund	Pooled separate accounts	N/A	1,124,587
	* Pimco Total Return Fund	Pooled separate accounts	N/A	1,380,458
	* Invsco Dynamics Fund	Pooled separate accounts	N/A	913,193
	* Alliance Brnstn Intl Val K	Pooled separate accounts	N/A	1,060,746
	* Dreyfus Appreciation Fund	Pooled separate accounts	N/A	741,627
	* Amer Funds Growth Fund of America R3	Pooled separate accounts	N/A	1,038,816
	* Nationwide Government Bond	Pooled separate accounts	N/A	487,352
	* VanKamp Real Estate Sec Fund A	Pooled separate accounts	N/A	476,769
	* Ycktmn Focs	Pooled separate accounts	N/A	68,032
	* NW Investment Dest Moderate Aggressive Fund	Pooled separate accounts	N/A	845,026
	* Davis NY Venture Fund A	Pooled separate accounts	N/A	639,458
	* Goldman Sachs Short Government Fund	Pooled separate accounts	N/A	459,713
	* Allber Smmdcap Val K	Pooled separate accounts	N/A	642,702
	* Opp Main St Small Cap Fund A	Pooled separate accounts	N/A	185,761
	* NW Investment Dest Aggressive Sc	Pooled separate accounts	N/A	407,184
	* NW Midcap Mkt Index Fund A	Pooled separate accounts	N/A	181,307
	* Opp Gold & Sp Mineral Fd A	Pooled separate accounts	N/A	249,307
	* Prud Jensen Nat Resources Fd A	Pooled separate accounts	N/A	158,177
	* NW Investment Dest Moderate Fund	Pooled separate accounts	N/A	398,393
	* Opp Global Fund Cls A	Pooled separate accounts	N/A	396,130
	* NW Investment Dest Moderate Conservative Fund	Pooled separate accounts	N/A	170,765
	* Legg Clrbdy Small Cap Fund	Pooled separate accounts	N/A	138,456
	* Opp Intl Bond Fund A	Pooled separate accounts	N/A	182,695
	* Opp Devl Market A	Pooled separate accounts	N/A	66,680
	* NW Investment Dest Conservative Fund	Pooled separate accounts	N/A	153,531
	* NW Money Market Inst	Pooled separate accounts	N/A	18,014
	* Janus Worldwide Fund	Pooled separate accounts	N/A	11,978
	* MFS International Value	Pooled separate accounts	N/A	14
	* American Century Ultra Fund	Pooled separate accounts	N/A	9,088
	* Fidelity Advanced Balanced Fund	Pooled separate accounts	N/A	5,424
	* Fidelity Advanced Mid Cap	Pooled separate accounts	N/A	46,751
	* Vanguard Healthcare Inv	Pooled separate accounts	N/A	31,437
	* PIMCO Real Return Inst	Pooled separate accounts	N/A	240,924
	* Janus Balanced Fund	Pooled separate accounts	N/A	938,260
	* Opp Strat Inc Fund Cls A	Pooled separate accounts	N/A	137,946
				<u>18,378,270</u>
	Notes Receivable from Participants			
	* Participant loans	2% to 8.5%		<u>107,320</u>
				<u>\$ 18,485,590</u>
	* Party-in-interest			

See independent auditor's report on supplemental information.

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name ACCELERATED HEALTH SYSTEMS LLC 401 PS PLAN

EIN: 36-4280414

Plan Sponsor's Name ACCELERATED HEALTH SYSTEMS LLC

PN: 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
	NATIONWIDE LIFE INS CO	POOLED SEPERATE ACCOUNT		17,419,717
	BOA Indexed Fixed Fund			958,553
	Plan Loans	Loans		107,320