Form 5500-SF

Department of the Treasury Internal Revenue Service

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

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

1210-0089

OMB Nos. 1210-0110

2010

This Form is Open to Public Inspection

P	Complete all entri	es in accor	dance witl	n the instructions to the Form 550	0-SF.					
	art I Annual Report Identification Inform									
For	calendar plan year 2010 or fiscal plan year beginning	01/01/201	1	and ending 0	08/17/2	2011				
Α.	This return/report is for:	П	multiple-e	employer plan (not multiemployer)		one-participant plan				
В	This return/report is for: first return/report	n/report								
	an amended return/re	port	short plan	year return/report (less than 12 mo	nths)					
<u> </u>	Check box if filing under: Form 5558	' · · ·		extension	,	DFVC program				
C	Ħ	ل_ نامت طمممتنمین	ı	, exterision	U bi vo piografii					
_	special extension (ent	•	,							
	art II Basic Plan Information—enter all reque	ested inform	ation		41					
	Name of plan	OFIT OLIA				Three-digit plan number				
BLUE	EGRASS NEUROLOGICAL SERVICES, PSC 401(K) PF	KOFII SHAF	RING PLAN	V		(PN) • 001				
					1c	Effective date of plan				
						01/01/2006				
2a	Plan sponsor's name and address (employer, if for sing	le-employer	plan)		2b	Employer Identification Number				
BLUE	EGRASS NEUROLOGICAL SERVICES PSC					(EIN) 16-1673385				
000 (COUNT FLEET CIRCLE				2c	Plan sponsor's telephone number 859-936-0094				
	VILLE, KY 40422				24	Business code (see instructions)				
					Zu	621111				
3a	Plan administrator's name and address (if same as Plan	n sponsor, e	nter "Same	e")	3b	Administrator's EIN				
BLUE	EGRASS NEUROLOGICAL SERVICES PSC 9	990 COUNT DANVILLE, F	FLEET CII	RĈLE		16-1673385				
	_	>/ ((V) LLL, (11 40422		3с	Administrator's telephone number 859-936-0094				
<u> </u>	f the name and/or FINI of the plan anamor has abanged	ainaa tha la	at ration/ra	nort filed for this plan anter the	46					
	f the name and/or EIN of the plan sponsor has changed name, EIN, and the plan number from the last return/rep			port filed for this plan, enter the	40	EIN				
					4c PN					
5a	Total number of participants at the beginning of the plan	5a	3							
b	Total number of participants at the end of the plan year				5b	0				
С	Total number of participants with account balances as				0.0					
	complete this item)				5c	0				
6a	Were all of the plan's assets during the plan year inves	sted in eligib	le assets?	(See instructions.)		Yes No				
b	Are you claiming a waiver of the annual examination ar					M v D v				
	under 29 CFR 2520.104-46? (See instructions on waiv	• •		•		Yes No				
Da	If you answered "No" to either 6a or 6b, the plan ca art III Financial Information	innot use F	orm 5500-	SF and must instead use Form 55	00.					
				()5		(1) = 1 (1)				
7	Plan Assets and Liabilities		_	(a) Beginning of Year 89824	1	(b) End of Year				
	Total plan assets		. 7a	0302-						
b	Total plan liabilities			89824	1	0				
<u>C</u>	Net plan assets (subtract line 7b from line 7a)		. 7с							
8	Income, Expenses, and Transfers for this Plan Year			(a) Amount		(b) Total				
а	Contributions received or receivable from: (1) Employers		. 8a(1)							
	(2) Participants		` ` `		\dashv					
	(3) Others (including rollovers)		, ,		\dashv					
b	Other income (loss)			179°	1					
_	,					1791				
Q C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		. 8c							
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)		. 8d	90699	9					
е	Certain deemed and/or corrective distributions (see ins									
f	Administrative service providers (salaries, fees, commis			916	5					
g g	Other expenses	•								
9 h	Total expenses (add lines 8d, 8e, 8f, and 8g)					91615				
;						-89824				
i	Net income (loss) (subtract line 8h from line 8c) Transfers to (from) the plan (see instructions)									
J	rianciolo to (nom) the plan (occ mondellono)		. 8i							

	Form 5500-SF 2010 Page 2- 1		_						
-	t IV Plan Characteristics								
а	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Char 2E 2F 2G 2J 2K 3D	acteris	tic Co	des in	the instru	ıctio	ns:		
2	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Chara	acteris	tic Cod	des in t	the instru	ctior	ns:		
art	V Compliance Questions								
)	During the plan year:		Yes	No		A	nount		
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X					
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X					
С	Was the plan covered by a fidelity bond?	10c	X					6	55000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X					
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X					
f	Has the plan failed to provide any benefit when due under the plan?	10f		X					
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X					
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X					
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i							
ırt	VI Pension Funding Compliance								
l	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 5500))	•			`		Ye	s	No
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code	e or se	ction 3	302 of	ERISA?.		Ye	s X	No
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)								
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instrugranting the waiverMon								
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				1				
b	b Enter the minimum required contribution for this plan year								
С	Enter the amount contributed by the employer to the plan for this plan year								
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)					_			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	Ш	No	Ш	N/A
rt	VII Plan Terminations and Transfers of Assets								
_					· <u></u>	_	X Vo	<u>,</u>	No

13a Has a resolution to terminate the plan been adopted during the plan year or any prior year? If "Yes," enter the amount of any plan assets that reverted to the employer this year.....

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

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

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

X Yes No

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

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

SIGN	Filed with authorized/valid electronic signature.	10/24/2011	NADINE JOHNSON						
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator						
SIGN									
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor						

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

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

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

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

	Part I Annual Report Identification Information											
Fo		01/01/2	2011	and ending		08/17/201	.1					
Α	This return/report is for:	multiple-	employer plan	(not multiemployer)		nt plan						
В	This return/report is for:	final retu	rn/report									
	an amended return/report	short pla	n year return/r	eport (less than 12 mo	nths)							
C	C Check box if filing under:				☐ DFVC program							
	special extension (enter description		_									
P	art II Basic Plan Information—enter all requested inform	ation										
1a	Name of plan				1b	Three-digit						
	BLUEGRASS NEUROLOGICAL SERVICES, PSC					plan number	001					
	401(K) PROFIT SHARING PLAN				10	(PN) Ffective date of	<u> </u>					
					1c Effective date of plan 01/01/2006							
2a	Plan sponsor's name and address (employer, if for single-employer BLUEGRASS NEUROLOGICAL SERVICES PSC	plan)			2b	Employer Identii	ication Number					
	BLUEGRASS NEUROLOGICAL SERVICES PSC				Ļ	(EIN) 16-167						
	***				2C	Plan sponsor's t (859) 936-0	elephone number					
	990 COUNT FLEET CIRCLE				2d	Business code (
	DANVILLE			40422		621111	·					
3a	Plan administrator's name and address (if same as Plan sponsor, e SAME	nter "Sam	e")		3b	Administrator's I	EIN					
					30	Administrator's t	elephone number					
						Administrator 5 t	elephone number					
4	If the name and/or EIN of the plan sponsor has changed since the la		port filed for t	his plan, enter the	4b	EIN						
	name, EIN, and the plan number from the last return/report. Sponso	or's name			Ac	4c PN						
5a	Total number of participants at the beginning of the plan year					1	3					
	b Total number of participants at the end of the plan year					-						
	C Total number of participants with account balances as of the end of the plan year (defined benefit plans do not											
	complete this item)						0					
	Were all of the plan's assets during the plan year invested in eligib			•••••	X Yes No							
b	Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility a	i public accountant (IQ	PA)		⊠ Yes ∏ No							
	If you answered "No" to either 6a or 6b, the plan cannot use Fo					•••••	₽ Ies □ Wo					
Pa	art III Financial Information											
7	Plan Assets and Liabilities		(a) B	eginning of Year		(b) End	of Year					
а	Total plan assets	7a		89,82	4		0					
b	Total plan liabilities	7b										
C	Net plan assets (subtract line 7b from line 7a)	7c		89,82	4		0					
8	Income, Expenses, and Transfers for this Plan Year			a) Amount		(b) T	otal					
а	Contributions received or receivable from: (1) Employers	8a(1)										
	(2) Participants			···	┥							
	(3) Others (including rollovers)				┪							
b	Other income (loss)	8b		1,79	┧							
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			╫		1,791					
d	Benefits paid (including direct rollovers and insurance premiums				_		27.32					
	to provide benefits)	8d		90,69	9							
e	Certain deemed and/or corrective distributions (see instructions)	8e			4							
Ť	Administrative service providers (salaries, fees, commissions)	8f		91	6							
g	Other expenses	. 8g			4-							
h :		8h			+		91,615					
i	Net income (loss) (subtract line 8h from line 8c) Transfers to (from) the plan (see instructions)	8i			+-		(89,824)					
	· · - · · · · · · · · · · · · · · · · ·	o:										

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	Form 5500-SF 2010	F	age 2								
Part	IV Plan Characteristics			all designed of the						The second second	
9a	f the plan provides pension benefits, enter the applicable pension fe	ature codes from the	List of Plan Char	acteris	stic Co	des in	the instruct	ions	: :		
	2E 2F 2G 2J 2K 3D f the plan provides welfare benefits, enter the applicable welfare fea	sture ender from the	List of Plan Char	octorie	tic Cor	toe in t	the instructi	ons	140		
b 1	the plan provides welfare benefits, enter the applicable welfare lea	ature codes nom the	List of Plati Chare	acter is	110 000	163 111	TIC IIISII GCII	0113.	1		
Part	/ Compliance Questions										
	During the plan year:				Yes	No	1	Amo	ount		
а	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiducions)	iary Correction Prog	ram)	10a		Х					
		any nonexempt transactions with any party-in-interest? (Do not include transactions reported)									
C	Was the plan covered by a fidelity bond?			10c	Х				65,000		
	Did the plan have a loss, whether or not reimbursed by the plan's fic or dishonesty?			10d		Х					
	Were any fees or commissions paid to any brokers, agents, or other insurance service or other organization that provides some or all of t instructions.)	the benefits under th	e plan? (See	10e		Х					
f	Has the plan failed to provide any benefit when due under the plan?	·		10f		Х					
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year end.)		10g		Х					
	If this is an individual account plan, was there a blackout period? (Se 2520.101-3.)			10h		Х					
	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-3			10i							
Part \	3										
	s this a defined benefit plan subject to minimum funding requiremen 5500))								Yes		Vo.
12	Is this a defined contribution plan subject to the minimum funding re	equirements of section	on 412 of the Code	or se	ction 3	802 of I	ERISA?		Yes	X N	lo
	If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicate f a waiver of the minimum funding standard for a prior year is being			.4:		-44		- 1-		•2020	
a	granting the waiver.	amortized in this pla	Mon	th	and e	Day	e date of th	Yea	ner rui r	ing	
	ou completed line 12a, complete lines 3, 9, and 10 of Schedule N				_						_
	Enter the minimum required contribution for this plan year					12b		_			_
	Enter the amount contributed by the employer to the plan for this pla Subtract the amount in line 12c from the amount in line 12b. Enter th				-	12c					_
	negative amount)					12d	7 v _ r	٦.	. г	7	_
Part \	Will the minimum funding amount reported on line 12d be met by the Plan Terminations and Transfers of Assets	tunding deadline?					Yes] N	10	N/A	1
											_
	las a resolution to terminate the plan been adopted during the plan							X	Yes	∐ N	lo
b \	f "Yes," enter the amount of any plan assets that reverted to the emp Were all the plan assets distributed to participants or beneficiaries, tr of the PBGC?	ransferred to anothe	r plan, or brought	under	the co	13a ntrol		X	Yes	Пи	0
C	f during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.)	this plan to another	plan(s), identify the	ne plar	n(s) to				100	⊔ "	
	c(1) Name of plan(s):				13c(2) EIN(s) 13c(3)				PN(s)	
						,	(-)	+	(-)	(0	
								_			
Cautio	n: A penalty for the late or incomplete filing of this return/repor	t will be assessed	unless reasonab	le cau	se is e	etabli	ished				_
Under SB or S	penalties of perjury and other penalties set forth in the instructions, I Schedule MB completed and signed by an enrolled actuary, as well a	declare that I have	examined this retu	ırn/rep	ort. in	cluding	if applicat	ole, a	a Sche ledge	edule and	_
	t is true, correct, and complete.	10/2-1:						_			_
SIGN	Simon delle Jurison	10/20/11	NADINE JOH		1011 N						_
	Signature of plan administrator	Date	Enter name of in	dividu	al sign	ing as	plan admin	istra	itor		_
SIGN	Signature of employer/plan sponsor	Date	Enter name of in	J1. 1 1	-1 -1						
	- Signature of Employel/Didit SUUIISUI	I MIN	color name of in	TIM/I/dill	al CIAN	10a ac	amplayor c	er nie	10 000	DOOF	

Date

Enter name of individual signing as employer or plan sponsor

Signature of employer/plan sponsor