Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CARDIOMEDICAL INC CASH BALANCE PENSION PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/2004

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

2032 TARPON BAT DRIVE SOUTH
NAPLES, FL 34119

2032 TARPON BAT DRIVE SOUTH
NAPLES, FL 34119

2b Employer Identification Number (EIN)
34-1894106

2c Sponsor's telephone number

2d Business code (see instructions)

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			
	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
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

2032 TARPON BAT DRIVE SOUTH
NAPLES, FL 34119

3b Administrator's EIN
34-1894106

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

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

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)

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 under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089

2007

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2007 or fiscal plan year beginning , **and ending** ,

A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☒ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ▶ ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan
CARDIOMEDICAL INC. CASH BALANCE PENSION PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan (mo., day, yr.) 01/01/2004

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

2032 TARPON BAY DRIVE SOUTH

NAPLES FL 34119-8811

2b Employer Identification Number (EIN) 34-1894106

2c Sponsor's telephone number 216-221-1243

2d Business code (see instructions) 423990

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 if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE ATTACHMENT — PETER T. PARAS
Signature of plan administrator Date Type or print name of individual signing as plan administrator

SIGN HERE — PETER T. PARAS
Signature of employer/plan sponsor/DFE Date Type or print name of individual signing as employer, plan sponsor or DFE

Official Use Only

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

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

b EIN

c Telephone number

6 Total number of participants at the beginning of the plan year	**6**	2
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**7a**	0
b Retired or separated participants receiving benefits	**7b**	0
c Other retired or separated participants entitled to future benefits	**7c**	0
d Subtotal. Add lines **7a, 7b,** and **7c**	**7d**	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**7e**	0
f Total. Add lines **7d** and **7e**	**7f**	0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**7g**	0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**7h**	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**7i**	0

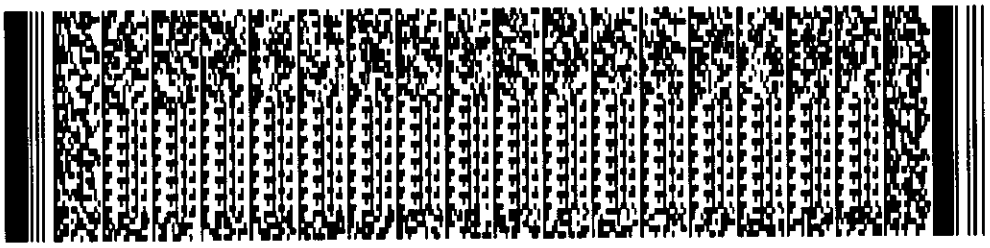
8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 1C

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)
- (1) [ ] Insurance
- (2) [ ] Code section 412(i) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) [ ] Insurance
- (2) [ ] Code section 412(i) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor



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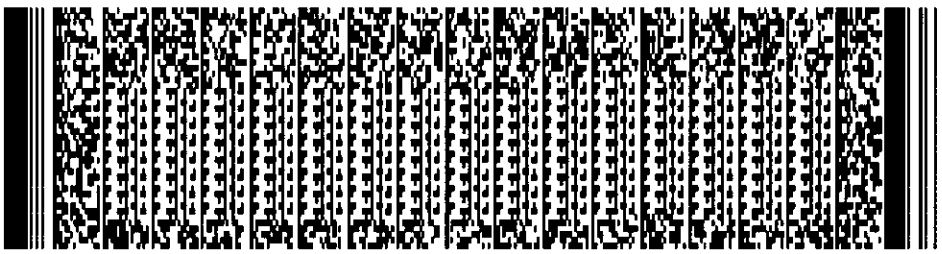
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) [X] **R** (Retirement Plan Information)
- (2) [ ] **B** (Actuarial Information)
- (3) [ ] **E** (ESOP Annual Information)
- (4) [ ] **SSA** (Separated Vested Participant Information)

b Financial Schedules

- (1) [ ] **H** (Financial Information)
- (2) [X] **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 I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

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.**

Official Use Only

OMB No. 1210-0110

2007

This Form is Open to Public Inspection.

For calendar year 2007 or fiscal plan year beginning , and ending ,

A Name of plan	**B** Three-digit plan number ▶
CARDIOMEDICAL INC. CASH BALANCE PENSION PLAN	002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
CARDIOMEDICAL, INC.	34-1894106

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

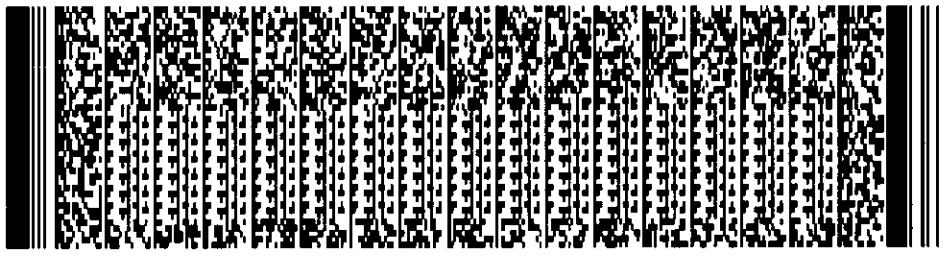
Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more then one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pey e specific dollar benefit at a future dete. 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.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plen assets	1a	1622498	0
b	Total plen liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	1622498	0
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable			
	(1) Employers	2a(1)	0	
	(2) Participants	2a(2)	0	
	(3) Others (including rollovers)	2a(3)	0	
b	Noncash contributions	2b	0	
c	Other income	2c	45054	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		45054
e	Benefits paid (including direct rollovers)	2e	1667053	
f	Corrective distributions (see instructions)	2f	0	
g	Certain deemed distributions of participant loens (see instructions)	2g	0	
h	Other expenses	2h	499	
I	Total expenses (add lines 2e, 2f, 2g, and 2h)	2I		1667552
j	Net income (loss) (subtract line 2i from line 2d)	2j		-1622498
k	Transfers to (from) the plan (see instructions)	2k		0

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	



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Official Use Only

			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Transactions During Plan Year

			Yes	No	Amount
4	During the plan year:				
a	Did the employer fail 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.)	4a		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 the participant's account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e	Was the plan covered by a fidelity bond?	4e	X		90000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j	X		
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☒ **Yes** ☐ **No** **Amount** 0

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)

2 0 0 7 3 2 0 2 0 G

Official Use Only

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under 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).

▶ **File as an Attachment to Form 5500.**

OMB No. 1210-0110

2007

This Form is Open to Public Inspection.

For calendar year 2007 or fiscal plan year beginning , and ending ,

A Name of plan
CARDIOMEDICAL INC. CASH BALANCE PENSION PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
CARDIOMEDICAL, INC.

D Employer Identification Number
34-1894106

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . 1 $ 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). _____ _____

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(c)(8) or ERISA section 302(c)(8)? . . . . . ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 7.

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 . . . . . ▶ Month ____ Day ____ Year ____

If you completed line 5, complete lines 3, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

6a 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 8a. Enter the result (enter a minus sign to the left of a negative amount) . . . . . 6c $

If you completed line 6c, skip lines 7 and 8 and complete line 9.

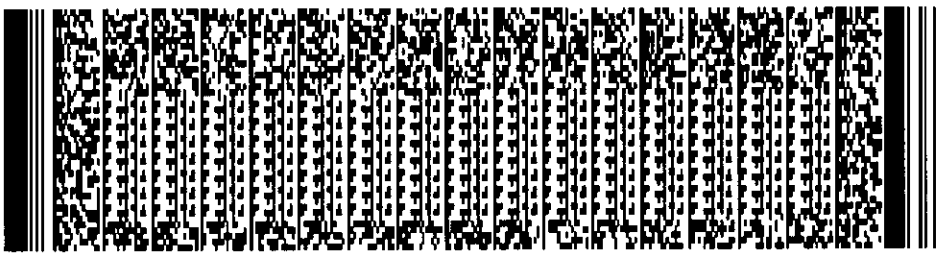
7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? . . ☐ Yes ☐ No ☐ N/A

Part III Amendments

8 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. (See instructions.) . . . . . ☐ Increase ☐ Decrease ☒ No

Part IV Coverage (See Instructions.)

9 Check the box for the test this plan used to satisfy the coverage requirements . . . . ☐ the ratio percentage test ☐ average benefit test



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Form **5558**
(Rev. January 2008)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)
CARDIOMEDICAL INC.

Number, street, and room or suite no. (If a P.O. box, see instructions)
2032 TARPON BAY DRIVE SOUTH

City or town, state, and ZIP code
NAPLES, FLORIDA 34119-8811

B Filer's identifying number (see instructions).
☑ Employer identification number (EIN).
34 1894106
☐ Social security number (SSN)

C Plan name	Plan number	Plan year ending— MM	DD	YYYY
1 CARDIOMEDICAL INC. CASH BALANCE PENSION PLAN	0 0 2	12	31	2007
2				
3				

Part II Extension of Time to File Form 5500 or Form 5500-EZ *(see instructions)*

1 I request an extension of time until 10 / 15 / 2008 to file Form 5500 or Form 5500-EZ.

The application is **automatically approved** to the date shown on line 1 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and **(b)** the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed in C above.

Note. A signature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ.

Part III Extension of Time to File Form 5330 *(see instructions)*

2 I request an extension of time until ___ / ___ / ___ to file Form 5330.
You may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ▶ a

b Enter the payment amount attached . . . . . ▶ b

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ▶ c

3 **State in detail why you need the extension**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ Paula Stanton Date ▶ 7/29/08

Form **2848**

(Rev. June 2008)
Department of the Treasury
Internal Revenue Service

Power of Attorney and Declaration of Representative

▶ Type or print. ▶ See the separate instructions.

OMB No. 1545-0150

For IRS Use Only
Received by:
Name
Telephone
Function
Date / /

Part I **Power of Attorney**

Caution: *Form 2848 will not be honored for any purpose other than representation before the IRS.*

1 **Taxpayer information.** Taxpayer(s) must sign and date this form on page 2, line 9.

Taxpayer name(s) and address

CARDIOMEDICAL INC
17841 LAKE AVE
LAKEWOOD, OH 44107

Social security number(s):

Employer identification number: 34 1894106

Daytime telephone number: (440) 478-4732

Plan number (if applicable): 002

hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

2 **Representative(s)** must sign and date this form on page 2, Part II.

Name and address

KIMBERLY A FLETT, SS&G FINANCIAL SERVICES INC
301 SPRINGSIDE DRIVE
AKRON, OH 44333

CAF No. 5005-89689R
Telephone No. 330-668-9696
Fax No. 330-668-2538
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address

JOHN T CAREY, SS&G FINANCIAL SERVICES INC
301 SPRINGSIDE DRIVE
AKRON, OH 44333

CAF No. 3200-71421R
Telephone No. 330-668-9696
Fax No. 330-668-2538
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address

CAF No.
Telephone No.
Fax No.
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

to represent the taxpayer(s) before the Internal Revenue Service for the following tax matters:

3 **Tax matters**

Type of Tax (Income, Employment, Excise, etc.) or Civil Penalty (see the instructions for line 3)	Tax Form Number (1040, 941, 720, etc.)	Year(s) or Period(s) (see the instructions for line 3)
Annual Return/Report of Employee Benefit Plan	5500	2006, 2007

4 **Specific use not recorded on Centralized Authorization File (CAF).** If the power of attorney is for a specific use not recorded on CAF, check this box. See the instructions for **Line 4. Specific Uses Not Recorded on CAF** . . . . ▶ ☐

5 **Acts authorized.** The representatives are authorized to receive and inspect confidential tax information and to perform any and all acts that I (we) can perform with respect to the tax matters described on line 3, for example, the authority to sign any agreements, consents, or other documents. The authority does not include the power to receive refund checks (see line 6 below), the power to substitute another representative or add additional representatives, the power to sign certain returns, or the power to execute a request for disclosure of tax returns or return information to a third party. See the line 5 instructions for more information.

Exceptions. An unenrolled return preparer cannot sign any document for a taxpayer and may only represent taxpayers in limited situations. See **Unenrolled Return Preparer** on page 1 of the instructions. An enrolled actuary may only represent taxpayers to the extent provided in section 10.3(d) of Treasury Department Circular No. 230 (Circular 230). An enrolled retirement plan administrator may only represent taxpayers to the extent provided in section 10.3(e) of Circular 230. See the line 5 instructions for restrictions on tax matters partners. In most cases, the student practitioner's (levels k and l) authority is limited (for example, they may only practice under the supervision of another practitioner).

List any specific additions or deletions to the acts otherwise authorized in this power of attorney: ....

6 **Receipt of refund checks.** If you want to authorize a representative named on line 2 to receive, BUT NOT TO ENDORSE OR CASH, refund checks, initial here ________ and list the name of that representative below.

Name of representative to receive refund check(s) ▶

For Privacy Act and Paperwork Reduction Act Notice, see page 4 of the instructions. Cat. No. 11980J Form **2848** (Rev. 6-2008)

RECEIVED OSC 35
JAN 03 2011

RECEIVED IN POA
IRS OGDEN UTAH

POA Processed

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0423404751
Feb. 22, 2011 LTR 2696C 0
34-1894106 200712 74 002
00018249

CARDIOMEDICAL INC
17841 LAKE AVE
LAKEWOOD OH 44107-1052

013921

DECLARATION

Under penalties of perjury, I declare that I have examined the return identified in this letter, including any accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct and complete. I understand that this declaration will become a permanent part of that return.

Signature of officer or trustee — Date: 3/12/11

President
Title