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 sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210-0110

1210-0089

2012

This Form is Open to Public Inspection

Pension Be	enerit Guaranty Corporation	▶ Complete all entries in acc	ordance with the instr	uctions to the Form 550	0-SF.						
Part I	Annual Report	Identification Information									
For calenda	ar plan year 2012 or fi	scal plan year beginning 01/01/2	012	and ending 1	12/31/2	2012					
	turn/report is for:	a single-employer plan the first return/report	a multiple-employer the final return/repor	plan (not multiemployer)		a one-particip	oant plan				
		an amended return/report	a short plan year retu	urn/report (less than 12 m	onths)	1					
C Check box if filing under:						DFVC program					
• Check	box ii iiiiiig under.	special extension (enter descrip				☐ 5. vo progra					
Don't II	Dania Dian Info	<u> </u>	,								
Part II		prmation—enter all requested info	rmation		46		1				
1a Name		IIC, P.S.C. PROFIT SHARING PLAN	l		ID	Three-digit plan number					
SOUTHOLL	TIAM MEDICAL CLIN	IIC, F.S.C. FROFT SHARING FLAN	•			(PN) •	001				
					1c	Effective date of	f plan				
						04/01/	•				
	ponsor's name and ac DHAM MEDICAL CLIN	Idress; include room or suite number NIC, PSC	(employer, if for a singl	e-employer plan)	2b	Employer Identification Number (EIN) 61-1292048					
6520 WEST	HIGHWAY 22				2c	Sponsor's telep		r			
	DD, KY 40014-0038				2d	Business code (ons)			
	dministrator's name a	nd address Same as Plan Sponso	or Name Same as Pl	an Sponsor Address	3b	Administrator's I	EIN 292048				
OUTH OLDF	TAM MEDICAL CLINI		OD, KY 40014-0038		3c Administrator's telephone number 502-241-8488						
		e plan sponsor has changed since th mber from the last return/report.	ne last return/report filed	for this plan, enter the	4b	EIN					
a Spons	or's name				4c	PN					
5a Total r	number of participants	at the beginning of the plan year			5a			8			
b Total r	number of participants	at the end of the plan year			5b			7			
		account balances as of the end of the	• •	•	5c			7			
6a Were	all of the plan's asset	s during the plan year invested in eli	gible assets? (See instru	uctions.)			X Yes	No			
•	•	f the annual examination and report			,		— · · · · ·	— □			
		? (See instructions on waiver eligibili					X Yes	No			
		ither line 6a or line 6b, the plan ca									
		or incomplete filing of this return/									
SB or Sche	, , ,	her penalties set forth in the instruct nd signed by an enrolled actuary, as plete.	•			O, 11	,				
SIGN	Filed with authorized	/valid electronic signature.	07/23/2013	ASHOK ALUR							
HERE	Signature of plan a	dministrator	Date	Enter name of individ	ual sig	ıning as plan adr	ninistrator				
SIGN											
HERE	Signature of emplo	over/nlan sponsor	Date	Enter name of individ	ual sin	ning as employe	r or nlan sno	nsor			
Preparer's		name, if applicable) and address; inc				parer's telephone					

Form 5500-SF 2012 Page **2**

Pai	t III Financial Information										
7	Plan Assets and Liabilities		(a) Beginning of Yea	ar			(b) En	d of Y	ear		
a	Total plan assets	7a	(a) Deginning of Tear				(b) End of Year 441582				
	Total plan liabilities	7b									
	Net plan assets (subtract line 7b from line 7a)	7c	38883	33			441582				
	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total				
	Contributions received or receivable from:		(a) Amount				(5)	Total			
	(1) Employers	8a(1)	577	9							
	(2) Participants	8a(2)									
	(3) Others (including rollovers)	8a(3)									
b	Other income (loss)	8b	5277	' 4							
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							58553	3	
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	580)4							
е	Certain deemed and/or corrective distributions (see instructions)	8e									
f	Administrative service providers (salaries, fees, commissions)	8f									
g	Other expenses	8g									
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							580	4	
	Net income (loss) (subtract line 8h from line 8c)	8i							5274	9	
	Transfers to (from) the plan (see instructions)	8j									
Par	t IV Plan Characteristics	<u> </u>	l								
	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 3D	feature co	des from the List of Plan Char	acteris	stic Co	des in	the instr	uctions	s:		
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	les from the List of Plan Chara	cterist	ic Cod	les in t	he instru	ctions:			
_											
Part	•						1				
10	During the plan year:	dana and dat	and an effect of the state of the	ı	Yes	No		Am	ount		
a	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	ıciary Corı	rection Program)	10a		X					
	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		X					
С	Was the plan covered by a fidelity bond?			10c	X					40	000
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	-		10d		X					
е	insurance service or other organization that provides some or all of	of the bene	efits under the plan? (See	100		X					
f	instructions.) Has the plan failed to provide any benefit when due under the plan			10e		Х					
	has the plan falled to provide any benefit when due under the plan	n?		10f							
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year e	end.)	10g		X					
h	2520.101-3.)			10h		X					
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i							
Part	VI Pension Funding Compliance										
11											
11a											
12	2 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?										
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)											
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month Day Year										
If	you completed line 12a, complete lines 3, 9, and 10 of Schedule	e MB (For	m 5500), and skip to line 13.				_				
b	Enter the minimum required contribution for this plan year					12b					

	Form 5500-SF 2012 Page 3 - 1			
	Enter the amount contributed by the employer to the plan for this plan year	12c		
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)	12d		
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No N/A
Part	VII Plan Terminations and Transfers of Assets			
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes X No	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	. 13a		
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the of the PBGC?	control		Yes X No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)	to		_
1	3c(1) Name of plan(s):	3c(2) E	IN(s)	13c(3) PN(s)
Part	VIII Trust Information (optional)			
	Name of trust	14b ⊤	rust's EIN	

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Comoration

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

This form is required to be filed under sections 104 and 4065 of the €mployee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

Complete all entries in accorda	ince with the instru	ctions to the Form 550	00-SF. J					
Part Annual Report Identification Information								
	01/2012	and ending	12/31/201	2				
A This return/report is for:	a one-participant plan							
	he final return/report							
☐ an amended return/report ☐ a	short plan year retui	n/report (less than 12 m	· · · · · · · · · · · · · · · · · · ·					
C Check box if filing under: Form 5558 automatic extension DFVC program								
special extension (enter description)								
Part II Basic Plan Information—enter all requested information	on		1 21	1				
1a Name of plan	0113D T310 DT 331		1b Three-digit					
SOUTH OLDHAM MEDICAL CLINIC, P.S.C. PROFIT	SHARING PLAN		plan number (PN) ▶	001				
			1c Effective date of	f nlan				
			04/01/1997					
2a Plan sponsor's name and address; include room or suite number (em SOUTH OLDHAM MEDICAL CLINIC, PSC	ployer, if for a single	-employer plan)	2b Employer Identi					
SOUTH OHDHAN MEDICAH CHINIC, PSC	•		(€IN) 61-129					
6520 West Highway 22			2c Sponsor's telep					
0020 West 11291Way 22			502-241-84					
CRESTWOOD KY 40014-0038		•	2d Business code ((see instructions)				
	По		621111	-th 1				
3a Plan administrator's name and address Same as Plan Sponsor Nar	ne USame as Plai	Sponsor Address	3b Administrator's 61-129204					
SOUTH OLDHAM MEDICAL CLINIC, PSC		•	3c Administrator's					
6500 Wash Wisham 00			502-241-84	•				
6520 West Highway 22		,						
CRESTWOOD KY 40014-0038								
4 If the name and/or EiN of the plan sponsor has changed since the las name, EIN, and the plan number from the last return/report.	t return/report filed fo	or this plan, enter the	4b EIN					
a Sponsor's name			4c PN					
5a Total number of participants at the beginning of the plan year			5a					
b Total number of participants at the end of the plan year		**	````	8				
A contract of the contract of			5b	7				
Number of participants with account balances as of the end of the plate complete this item)	n year (defined bene	ent plans do not	5c	7				
6a Were all of the plan's assets during the plan year invested in eligible				🛛 Yes 📗 No				
b Are you claiming a waiver of the annual examination and report of an	independent qualifie	d public accountant (IQI	PA)					
under 29 CFR 2520.104-46? (See instructions on waiver eligibility and	d conditions.)		E FF00	X Yes No				
If you answered "No" to either line 6a or line 6b, the plan cannot								
Caution: A penalty for the late or incomplete filing of this return/repor								
Under penalties of perjury and other penalties set forth in the instructions, I SB or Schedule MB completed and signed by an enrolled actuary, as well a	declare that I have as the electronic ver	examined this return/rep sion of this return/report	oort, including, if application and to the best of my	able, a Schedule				
belief, it is true, correct, and complete.	ac the electronic for	or or ano retainineport,	, and to the best of my	Michieuge and				
	· , ,	1.011011 1.110						
SIGN SIGN SIGN SIGN SIGN SIGN SIGN SIGN	7/12/13	ASHOK ALUR						
Signature of plan administrator Date Enter name of individual signing as plan administrator								
SIGN UL. O								
alguature of employer/plan sponsor	Date	Enter name of individu						
Preparer's name (including firm name, if applicable) and address; include r	oom or suite numbe	r (optional)	Preparer's telephone	number (optional)				
		İ	4					
		l						
		1						

Pa	ntallia Financial Information							
7	Plan Assets and Liabilities	(a) Beginning of Ye					(b) End of Year	
а	Total plan assets	7a	388833			3 441		
b	Total plan liabilities	7b						
С	Net plan assets (subtract line 7b from line 7a)	7c	. 3	888	33		441582	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount			(b) Total		
а	Contributions received or receivable from: (1) Employers	8a(1)	577					
	(2) Participants	8a(2)						
	(3) Others (including rollovers)	8a(3)						
ь	Other income (loss)	8b		527	74			
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				581		
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		58	04			
е	Certain deemed and/or corrective distributions (see instructions)	8e						
	Administrative service providers (salaries, fees, commissions)	8f						
g	Other expenses	8g						
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					5804	
i	Net income (loss) (subtract line 8h from line 8c)	8i					52749	
j	Transfers to (from) the plan (see instructions)	8i	<u> Эмеричинан ини ини ини ини ини ини ини ини ини</u>	WHO OF THE ST				
Ба	Plan Characteristics	<u> </u>			機能			
	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 3D	feature co	des from the List of Plan Char	acteri	stic Co	odes in	the instructions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature code	es from the List of Plan Chara	cteris	tic Cod	les in t	the instructions:	
Par	Compliance Questions							
10	During the plan year:				Yes	No	Amount	
a	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidure)			10a		х		
b	Were there any nonexempt transactions with any party-in-interest on line 10a.)	? (Do not i	nclude transactions reported	10b		х		
С	Was the plan covered by a fidelity bond?		***************************************	10c	х		40000	
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	fidelity bor	nd, that was caused by fraud	10d		х		
e	Were any fees or commissions paid to any brokers, agents, or oth insurance service or other organization that provides some or all cinstructions.)	f the bene	fits under the plan? (See	10e		х		
f	Has the plan failed to provide any benefit when due under the plan	n?	***************************************	10f		·X		
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year e	nd.)	10g		Х		
. h	If this is an individual account plan, was there a blackout period? (2520.101-3.)			10h		X		
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i				
Part	VI Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum funding requirements 500) and line 11a below)	ents? (If "Y	es," see instructions and com	plete	Sched	lule SE	G (Form Yes No	
_11a	Enter the amount from Schedule SB line 39				- 1	11a		
_12	12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?							
	(if "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,							
	If a waiver of the minimum funding standard for a prior year is bein granting the waiver.		Mon	ctions, th	, and e	nter th Day	ne date of the letter ruling Year	
	you completed line 12a, complete lines 3, 9, and 10 of Schedule						·	
<u>b</u>	Enter the minimum required contribution for this plan year				<u></u>	12b		

••	Form 5500-SF 2012	Page 3				•
<u> </u>						
C	Enter the amount contributed by the employer to the plan	for this plan year] 12c		
d	Subtract the amount in line 12c from the amount in line 12 negative amount)			12d		
е	Will the minimum funding amount reported on line 12d be	met by the funding deadline?	?		Yes	No ∏ N/A
Part	Plan Terminations and Transfers of As	ssets				
13a	Has a resolution to terminate the plan been adopted in any pla	an year?		🔲 Ү	'es X No	
	If "Yes," enter the amount of any plan assets that reverted	to the employer this year		13a		
b	Were all the plan assets distributed to participants or bene of the PBGC?					Yes 🗓 No
С	If during this plan year, any assets or liabilities were trans which assets or liabilities were transferred. (See instruction	ferred from this plan to anoth				
1	3c(1) Name of plan(s):			13c(2) El	N(s)	13c(3) PN(s)
		·				
Part	VIII Trust Information (optional)					
14a	Name of trust			14b Tr	ust's EIN	
		•				