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

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

A This return/report is for: [X] single-employer plan [ ] multiple-employer plan (not multiemployer) [ ] one-participant plan

B This return/report is for: [ ] first return/report [X] final return/report

[ ] an amended return/report [ ] short plan year return/report (less than 12 months)

C Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] DFVC program

[ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C. DEFINED BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/2003

2a Plan sponsor's name and address (employer, if for single-employer plan)
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C.

4815 PAULSEN STREET
SAVANNAH, GA 31405

2b Employer Identification Number (EIN) 58-1153413

2c Plan sponsor's telephone number 912-352-2324

2d Business code (see instructions) 621210

3a Plan administrator's name and address (if same as Plan sponsor, enter "Same")
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C. 4815 PAULSEN STREET SAVANNAH, GA 31405

3b Administrator's EIN 58-1153413

3c Administrator's telephone number 912-352-2324

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. Sponsor's name

4b EIN

4c PN

5a Total number of participants at the beginning of the plan year	**5a**	23
b Total number of participants at the end of the plan year	**5b**	0
c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	**5c**	

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] No

b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) [X] Yes [ ] No

If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1227530	0
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1227530	0

8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from: **(1)** Employers	8a(1)		
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	63150	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		63150
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1290680	
e 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		1290680
i Net income (loss) (subtract line 8h from line 8c)	8i		-1227530
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
1A 1I 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 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? (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	
c Was the plan covered by a fidelity bond?	10c	X		250000
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	
e 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			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500)) [X] Yes [ ] No

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? [ ] Yes [X] No

(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)

a 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 MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year	12b	
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 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d	

e 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 during the plan year or any prior year? [X] Yes [ ] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year | 13a | 0

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? [X] Yes [ ] No

c 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)

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 HERE	Filed with authorized/valid electronic signature.	10/17/2011	CLIFFORD J. BERGER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2011	CLIFFORD J. BERGER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

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

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C. DEFINED BENEFIT PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C.

D Employer Identification Number (EIN)
58-1153413

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [X] 100 or fewer [ ] 101-500 [ ] More than 500

Part I Basic Information

1	Enter the valuation date: Month 01 Day 01 Year 2010			
2	Assets:			
a	Market value	**2a**		1227529
b	Actuarial value	**2b**		1227529
3	Funding target/participant count breakdown		**(1)** Number of participants	**(2)** Funding Target
a	For retired participants and beneficiaries receiving payment	**3a**	0	0
b	For terminated vested participants	**3b**	14	106277
c	For active participants:			
	(1) Non-vested benefits	**3c(1)**		5767
	(2) Vested benefits	**3c(2)**		1225781
	(3) Total active	**3c(3)**	10	1231548
d	Total	**3d**	24	1337825
4	If the plan is at-risk, check the box and complete items (a) and (b) [ ]			
a	Funding target disregarding prescribed at-risk assumptions	**4a**		
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	**4b**		
5	Effective interest rate	**5**		6.07 %
6	Target normal cost	**6**		

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE

	03/03/2011
Signature of actuary	Date
LORRAINE DORSA	08-04253
Type or print name of actuary	Most recent enrollment number
DORSA CONSULTING SERVICES, INC.	904-249-9171
Firm name	Telephone number (including area code)
13901 SUTTON PARK DRIVE SOUTH SUITE 150 JACKSONVILLE, FL 32224	
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

Part II Beginning of year carryover and prefunding balances

		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	61035	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	31475	0
9	Amount remaining (Item 7 minus item 8)	29560	0
10	Interest on item 9 using prior year's actual return of 8.70 %	2572	
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year)		0
b	Interest on (a) using prior year's effective rate of 6.12 %		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance		
12	Reduction in balances due to elections or deemed elections		
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12)	32132	0

Part III Funding percentages

14	Funding target attainment percentage	14	89.35 %
15	Adjusted funding target attainment percentage	15	89.35 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	84.57 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and liquidity shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
			Totals ► 18(b)	0	18(c) 0

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a	Contributions allocated toward unpaid minimum required contribution from prior years.	19a	
b	Contributions made to avoid restrictions adjusted to valuation date	19b	
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? [X] Yes [ ] No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? [ ] Yes [X] No

c If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:

a Segment rates:

1st segment:	2nd segment:	3rd segment:	
4.60 %	6.65 %	6.76 %	☐ N/A, full yield curve used

b Applicable month (enter code)	**21b**	0
22 Weighted average retirement age	**22**	65

23 Mortality table(s) (see instructions) ☒ Prescribed - combined ☐ Prescribed - separate ☐ Substitute

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes	☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes	☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment	☐ Yes	☒ No

27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment	**27**	

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years	**28**	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a)	**29**	
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29)	**30**	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions)	**31**	0

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	88915	18435
b Waiver amortization installment	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	**33**	
34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33)	**34**	18435

	Carryover balance	Prefunding balance	Total balance
35 Balances used to offset funding requirement	18435	0	18435

36 Additional cash requirement (item 34 minus item 35)	**36**	0
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c)	**37**	
38 Interest-adjusted excess contributions for current year (see instructions)	**38**	0
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37)	**39**	0
40 Unpaid minimum required contribution for all years	**40**	0

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

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Single-Employer Defined Benefit Plan Actuarial Information

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OMB No. 1210-0110

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▶ Round off amounts to nearest dollar.

▶ Caution: A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P. C. DEFINED BENEFIT PLAN

B Three digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
SOUTHEASTERN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.C.

D Employer Identification Number (EIN) 58-1153413

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [X] 100 or fewer [ ] 101-500 [ ] More than 500

Part I Basic Information

1 Enter the valuation date: Month 01 Day 01 Year 2010

2 Assets:

a	Market value	2a	1227529
b	Actuarial value	2b	1227529

3 Funding target/participant count breakdown

			(1) Number of participants	(2) Funding Target
a	For retired participants and beneficiaries receiving payment	3a	0	0
b	For terminated vested participants	3b	14	106277
c	For active participants:			
	(1) Non-vested benefits	3c(1)		5767
	(2) Vested benefits	3c(2)		1225781
	(3) Total active	3c(3)	10	1231548
d	Total	3d	24	1337825

4 If the plan is at-risk, check the box and complete items (a) and (b) [ ]

a	Funding target disregarding prescribed at-risk assumptions	4a	
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	4b	
5	Effective interest rate	5	6.07%
6	Target normal cost	6	0

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE

Signature of actuary

3/3/11
Date

Lorraine Dorsa
Type or print name of actuary

0804253
Most recent enrollment number

Dorsa Consulting Services, Inc.
Firm name

904-249-9171
Telephone number (including area code)

13901 Sutton Park Drive South
Suite 150
Jacksonville FL 32224
Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

Plan Name:Southeastern Oral and Maxillofacial Surgery Associates, P.C.Defined Benefit Plan
EIN:58-1153413
PIN:002
Plan Year End:12/31/2010

Schedule SB - Line 22 - Description of Weighted Average Retirement Age

(a) Target Liability	(b) NRA	(a) x (b) Weighting	Weighted Avg Retirement Age
507755	65	33004075	
8032	65	522080	
12203	65	793195	
3014	65	195910	
1182	65	76830	
25873	65	1681745	
7392	65	480480	
34584	65	2247960	
631513	65	41048345	
2766	65	179790	
434	65	28210	
10502	65	682630	
32312	65	2100280	
22735	65	1477775	
356	65	23140	
3476	65	225940	
327	65	21255	
13401	65	871065	
1314	65	85410	
132	65	8580	
39	65	2535	
18288	65	1188720	
195	65	12675	
1337825	1365	86958625	65

Name of Plan: Southeastern Oral Surgery, P.C. Defined Benefit Plan
Plan Sponsor's EIN: 58-1153413
Plan Number: 002
Plan Year End: December 31, 2010

Schedule SB, Part V - Statement of Actuarial Assumptions/Methods

Probability of Lump Sum: 99%

Salary Scale
Male: 0.00%
Female: 0.00%

Withdrawal
Male: None
Female: None

Withdrawal-Select
Male: None
Female: None

Early Retirement Rates
Male: None
Female: None

Subsidized Early Retirement Rates
Male: None
Female: None

Disability Rates
Male: None
Female: None

	Mortality	Setback
Male:	None	None
Female:	None	None

Late Retirement Rates
Male: None
Female: None

Marriage Probability		Setback
Male:	0.00%	0
Female:	0.00%	
Expense loading:	0.00%	

Normal cost expense load: 0.00%

Plan Name:	Southeastern Oral Surgery, P.C. Defined Benefit Plan
EIN:	58-1153413
PIN:	002
Plan Year End:	December 31, 2010

Schedule SB - Summary of Plan Provisions

Employer and Plan Data

Initial effective date	01/01/2000
Plan year begins	01/01/2010
Plan year ends	12/31/2010
Valuation date	01/01/2010

Normal Retirement

Minimum age	65
Minimum years of service	0
Minimum years of participation	5
Retirement date	1st of month following

Eligibility Requirements

Waiting period (mos)	99
Minimum age	21
Minimum age (mos)	0

Vesting

Primary	Secondary
Vesting Schedule	Vesting Schedule
2/20	N/A

Benefits

Type of Formula: Unit benefit non-integrated

Formula Name: Benefit formula

Effective Date: 01/01/2003

Unit type:	Percent		
Unit based on:	Participation		
Maximum total percent:	0.00%		
Tiers based on:	None		
First tier:	4.60%	for 1st	None
Second tier:	None	for next	None
Third tier:	None	for remaining yrs	

Maximum credit:

Past years:	99
Future years:	99
Total years:	10

Schedule SB, line 32 - Schedule of Amortization Bases

Charges/Credits

Type of Base	Effective Date	Interest Rate	Initial Amount	Initial Amort	Current Balance	Rem Amort	Payment
Shortfall	01/01/2009	4.60 / 6.65	186,919	7.00	166,941	6.00	31,475
Shortfall	01/01/2010	4.60 / 6.65	-78,026	7.00	-78,026	7.00	-13,040
Totals							18,435

Name of Plan: Southeastern Oral Surgery, P.C. Defined Benefit Plan
Plan Sponsor's EIN: 58-1153413
Plan Number: 002
Plan Sponsor's Name: Southeastern Oral & Maxillofacial Surgery Associates, P.C.