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).

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

2011

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

Annual Report Identification Information For calendar plan year 2011 or fiscal plan year beginning and ending X a single-employer plan a multiple-employer plan (not multiemployer) a one-participant plan A This return/report is for: the first return/report **B** This return/report is: the final return/report an amended return/report a short plan year return/report (less than 12 months) Form 5558 automatic extension DFVC program C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan number EAR, NOSE & THROAT PHYS. N. MISS. 401K PLAN (PN) ▶ 002 1c Effective date of plan 07/01/1976 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number EAR, NOSE & THROAT PHYSICIANS OF NORTH MISSISSIPPI, P.A. 64-0574599 (EIN) 2c Sponsor's telephone number 662-844-7540 P.O. BOX 2180 TUPELO, MS 38803-2180 2d Business code (see instructions) 621111 3a Plan administrator's name and address (if same as plan sponsor, enter "Same") 3b Administrator's EIN 64-0574599 EAR, NOSE & THROAT PHYSICIANS OF NORTH P.O. BOX 2180 MISSISSIPPI, P.A. TUPELO, MS 38803-2180 3c Administrator's telephone number 662-844-7540 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN name, EIN, and the plan number from the last return/report. 4c PN Sponsor's name 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..... 50 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 48 complete this item)..... **6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) **b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) Yes under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)..... If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Financial Information Plan Assets and Liabilities (b) End of Year (a) Beginning of Year 3863353 5054228 Total plan assets..... 7a 0 7b Total plan liabilities..... 5054228 3863353 Net plan assets (subtract line 7b from line 7a)..... 7с Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total a Contributions received or receivable from: 67576 8a(1) (1) Employers 122358 (2) Participants 8a(2) (3) Others (including rollovers)..... 8a(3) -282744 **b** Other income (loss)..... 8b -92810 Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8с Benefits paid (including direct rollovers and insurance premiums 333872 to provide benefits)..... 8d Certain deemed and/or corrective distributions (see instructions) ... 8e Administrative service providers (salaries, fees, commissions)....... 8f Other expenses..... 8g 333872 Total expenses (add lines 8d, 8e, 8f, and 8g)..... 8h -426682 Net income (loss) (subtract line 8h from line 8c)..... 8i 1617557 Transfers to (from) the plan (see instructions)

Form	5500-	SF	201

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Part IV	Plan	Characteristics

- If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 9a 2E 2G 2J 2K 3D
- If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

0 a	V Compliance Questions	1	v.			_		
а	During the plan year:		Yes	No		Am	ount	
	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	<u> </u>			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	<u> </u>			
С	Was the plan covered by a fidelity bond?	10c	Χ		1			50000
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		Χ				
f	Has the plan failed to provide any benefit when due under the plan?	10f		Χ	i			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10q		Χ				
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR	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						
art	VI Pension Funding Compliance							
1	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and comp 5500))						Yes	
2	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code						Yes	X N
_	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)	0. 00	0				1	ш
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruct granting the waiver							
lf y	ou 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				
С	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 o negative amount)			12d				
u					Yes		No	N/A
	Will the minimum funding amount reported on line 12d be met by the funding deadline?							
e art					'es X	No		
e art	VII Plan Terminations and Transfers of Assets				es X	No		
e art 3a	Plan Terminations and Transfers of Assets Has a resolution to terminate the plan been adopted in any plan year?	1:	3a	Y	es X		Yes	 X N
e art 3a b	Plan Terminations and Transfers of Assets Has a resolution to terminate the plan been adopted in any plan year?	1:	3a the co	Y	es X		Yes	× N
e art 3a b	Plan Terminations and Transfers of Assets Has a resolution to terminate the plan been adopted in any plan 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 u of the PBGC? If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the	1:	3a the co	Y] Yes	
e art 3a b	Plan Terminations and Transfers of Assets Has a resolution to terminate the plan been adopted in any plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year	1:	3a the co	ntrol				

belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	10/01/2012	J. MONTGOMERY BERRY, MD
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

OMB Nos. 1210-0110 Short Form Annual Return/Report of Small Employee Form 5500-SF 1210-0089 Benefit Plan Department of the Treasury 2011 Internal Revenue Service 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 Department of Labor This Form is Open to Public Employee Benefits Security Administration the Internal Revenue Code (the Code). Inspection Pension Benefit Guaranty Corporation > Complete all entries in accordance with the instructions to the Form 5500-SF Part I Annual Report Identification Information 01/01/2011 12/31/2011 For calendar plan year 2011 or fiscal plan year beginning and ending a single-employer plan a one-participant plan A This return/report is for: a multiple-employer plan (not multiemployer) the first return/report the final return/report B This return/report is: an amended return/report a short plan year return/report (less than 12 months) Form 5558 automatic extension DFVC program C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information 1b Three-digit 1a Name of plan plan number EAR, NOSE & THROAT PHYS. N. MISS. 401K PLAN 002 (PN) 🕨 1c Effective date of plan 07/01/1976 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number EAR, NOSE & THROAT PHYSICIANS OF NORTH MISSISSIPPI, P.A. (EIN) 64-0574599 2c Sponsor's telephone number P.O. BOX 2180 662-844-7540 2d Business code (see instructions) TUPELO MS 38803-2180 621111 3a Plan administrator's name and address (if same as plan sponsor, enter "Same") EAR, NOSE & THROAT PHYSICIANS OF NORTH MISSISSIPPI, P.A. 3b Administrator's EIN 64-0574599 Administrator's telephone number BOX 2180 662-844-7540 38803-2180 MS If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN name. EIN, and the plan number from the last return/report. 4c PN a Sponsor's name 5a Total number of participants at the beginning of the plan year..... 56 5a b Total number of participants at the end of the plan year..... 5b 50 c Number of participants with account balances as of the end of the plan year (defined benefit plans do not 48 complete this item)... X Yes 6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) X Yes No under 29 CFR 2520.104-46? (See instructions on walver eligibility and conditions.) 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 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year a Total plan assets..... 7a 3863353 5054228 0 b Total plan liabilities...... 7b 5054228 C Net plan assets (subtract line 7b from line 7a)..... 3863353 7c Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total a Contributions received or receivable from: 67576 8a(1) (1) Employers 122358 (2) Participants 8a(2) (3) Others (including rollovers)...... 8a(3) b Other income (loss)..... -282744 8b C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) -92810 8c d Benefits paid (including direct rollovers and insurance premiums 333872 8d to provide benefits)..... @ Certain deemed and/or corrective distributions (see instructions)... f Administrative service providers (salaries, fees, commissions)..... 8f g Other expenses..... 80 333872 h Total expenses (add lines 8d, 8e, 8f, and 8g)...... 8h Net income (loss) (subtract line 8h from line 8c)..... -426682

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1617557

Transfers to (from) the plan (see instructions).....

For Paperwork Reduction Act Notice and OMS Control Numbers, see the instructions for Form 5500-9F

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Par	IV Plan Characteristics	55-07 0-3 5			40-0-1		6.000°00.000.000.000.0000.0000.0000.000	
	a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2G 2J 2K 3D							
b	If the plan provides welfare benefits, enter the applicable welfare feat	ture codes from the l	ist of Plan Charac	cterist	ic Cod	es in t	he instruction	ons:
Part	V Compliance Questions				***************************************	**********	e de la companya de l	······································
10	During the plan year:			***************************************	Yes	No		Amount
а	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-1027 (See instructions and DOL's Voluntary Fiducians).			10a		Х		The second secon
b	b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)					Х		
С	Was the plan covered by a fidelity bond?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10c	Х	***************************************		500000
d	Did the plan have a loss, whether or not reimbursed by the plan's fid or dishonesty?	* '	* }	10d		х		and the same of th
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.)					х		varanta dake manaka manaka misaka misaka di Paraka kan dake dahari kan dake dake dake dake dake dake dake dake
f	Has the plan failed to provide any benefit when due under the plan?	************************		10f		Х		
q	Did the plan have any participant toans? (If "Yes," enter amount as o	of year end.)		10g		Х		who do the Western Property and the State of
h	If this is an Individual account plan, was there a blackout period? (Se 2520.101-3.)	e instructions and 2	9 CFR	10h		Х		
9 10000	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	required notice or or	ne of the	10ī		**************		
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11	Is this a defined benefit plan subject to minimum funding requiremen 5500)).							∏ Yes ∏ No
12	Is this a defined contribution plan subject to the minimum funding re							Yes X No
а	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable if a waiver of the minimum funding standard for a prior year is being granting the waiver.	amortized in this pla	n year, see instruc	itions,	and e	nter th Day	ne date of th	e letter ruling Year
H	ou completed line 12a, complete lines 3, 9, and 10 of Schedule N	//B (Form 5500), and	d skip to line 13.		r~-		r	
b	Enter the minimum required contribution for this plan year				···	12b		**************************************
	Enter the amount contributed by the employer to the plan for this plan				··· -	12¢		
d	Subtract the amount in line 12c from the amount in line 12b. Enter th negative amount)			,		12d		ed prof
-	Will the minimum funding amount reported on line 12d be met by the	funding deadline?	***************************************				Yes	No NA
Part			No-20-Complete Complete Comple			-harmai		WORLDWAY AND A STATE OF THE STA
13a	Has a resolution to terminate the plan been adopted in any plan year? \dots	***************************					res X No	
	If "Yes," enter the amount of any plan assets that reverted to the emp	***************************************					***************************************	
b	Were all the plan assets distributed to participants or beneficiaries, tr of the PBGC?	************************	********************					Yes X No
	If 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 th	e plai				t right Park of the case of th
	3c(1) Name of plan(s):			<u> </u>	130	c(2) E	N(s)	13c(3) PN(s)
								on the second se
Caut	on: A penalty for the late or incomplete filing of this return/repor	t will be assessed	unless reasonabl	e cau	se is	establ	ished.	
SB o	r penalties of perjury and other penalties set forth in the instructions, I Schedule MB completed and signed by an enrolled actuary, as well a , it is true, corect and complete.	declare that I have as the electronic ver	examined this return/r	irn/report	ort, in , and t	cludin o the	g, if applical best of my k	ble, a Schedule nowledge and
SIG	1/1/11/h/	10/1/2012	J. Montgome	ery	Beri	cy,	MD	
HER		Date	Enter name of in					nistrator
SIG			J. Montgome		au managar.			
HER	Signature of employer/plan sponsor	Date	Enter name of in	dividu	ıal sigr	ning a	s employer (or plan sponsor