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).

2042

2012

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

Р	ension Be	nefit Guaranty Corporation	▶ Complete all entries in acc	cordance	with the instruc	tions to the Form 550	0-SF.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Pa	art I	Annual Report I	dentification Information								
For	calenda	ar plan year 2012 or fisc	cal plan year beginning 01/01/2	2012		and ending	12/31/2	2012			
		arrivioport is for:	a single-employer plan			an (not multiemployer)	ployer) a one-participant plan				
B This return/report is: ☐ the first return/report ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐											
	an amended return/report a short plan year return/report (less than 12 m						onths)				
C Check box if filing under: Form 5558 automatic extension							DFVC progra	ım			
special extension (enter description)											
Pa	art II	Basic Plan Infor	mation—enter all requested info	ormation							
	Name						1b	Three-digit			
ABERDEEN EYE CLINIC, PA PROFIT SHARING PLAN							plan number	004			
							4.	(PN) •	001		
						1c Effective date of plan 01/01/2004					
22	Dlon or	onnor's name and add	draga: include room or quite numbe	r (omploy	or if for a single of	ampleyer plan)	2h				
		EYE CLINIC, PA	dress; include room or suite numbe	i (employ	er, ir ior a sirigie-e	employer plan)	20	Employer Identification (EIN) 20-15	93875		
							20	Sponsor's telep			
P O	BOX 95	55					20		e (see instructions)		
		, MS 39730					2d	Business code (
								62132	,		
3a	Plan ad	dministrator's name and	d address XSame as Plan Sponso	or Name	Same as Plan	Sponsor Address	3b	Administrator's	EIN		
			_		_		_				
							3c	Administrator's	telephone number		
4	4 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.					TO LIIV					
а	Sponso	or's name					4c	PN			
5a	Total r	number of participants a	at the beginning of the plan year				5a		8		
b	Total r	number of participants a	at the end of the plan year				5b		0		
С	Numbe	er of participants with a	account balances as of the end of the	he plan ye	ear (defined benef	fit plans do not					
	compl	ete this item)					5c		0		
6a		•	during the plan year invested in eli	-	•	•			X Yes No		
b			the annual examination and report						X Yes No		
			(See instructions on waiver eligibil ther line 6a or line 6b, the plan ca	-					M 103 140		
Cau											
			or incomplete filing of this return, her penalties set forth in the instruct						ahle a Schedule		
			d signed by an enrolled actuary, as								
beli	ef, it is t	rue, correct, and compl	lete.								
SIG	N	Filed with authorized/v	valid electronic signature.	0	7/24/2013	DR. CONNIE LONG					
HEF											
		Signature of plan ad			ate	Enter name of individ	ual sig	ining as plan adn	ninistrator		
SIG		Filed with authorized/v	valid electronic signature.	0	7/24/2013	DR. CONNIE LONG					
HEF		Signature of employer/plan sponsor Date Enter name of individu									
			ame, if applicable) and address; inc	clude roor	n or suite number	(optional)	Prep	arer's telephone	number (optional)		
ADVANTAGE NETWORK FINANCIAL SVCS 389 HIGHWAY 21						985-792	2-0771				
SUITE 401											
MAD	ISONV	ILLE, LA 70447									

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	1 01111 00000 01 2012		r age z						
Pa	rt III Financial Information								
7	n Assets and Liabilities (a) Beginning of Yea			ar	(b) End of Year				
а	tal plan assets							()
b	Total plan liabilities	7b)	
С	Net plan assets (subtract line 7b from line 7a)	7с	10834	108348				C)
8	ome, Expenses, and Transfers for this Plan Year (a) Amount						(b) Total		
а	Contributions received or receivable from:								
	(1) Employers	• • • • • • • • • • • • • • • • • • • •							
	(2) Participants	8a(2)							
	(3) Others (including rollovers)	8a(3)							
	Other income (loss)	8b		0					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						1924	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d	11027	' 2					
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						110272	2
i	Net income (loss) (subtract line 8h from line 8c)	8i						-108348	3
j	Transfers to (from) the plan (see instructions)	8j							
Pai	t IV Plan Characteristics	<u> </u>							
9a	If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 3D	feature co	odes from the List of Plan Char	acteris	stic Co	des in	the instruction	ons:	
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 instruction	ns:	
D	(V Q - mm m - m Q - mm m - m								
Par	•			Yes					
10	During the plan year:					No	A	mount	
	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	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)				X			
D	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	Χ				40000
d	, ,			100					10000
u	or dishonesty?	-		10d		X			
е	,								
	insurance service or other organization that provides some or all of instructions.)		• •	10e		X			
f	Has the plan failed to provide any benefit when due under the plan					X			
				10f		Χ			
g				10g		^			
"	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									
11	Is this a defined benefit plan subject to minimum funding requirem							☐ Yes	X No
110	5500) and line 11a below)						<u>[</u>	163	^ INO
	Enter the amount from Schedule SB line 39					11a	EDICAS	Yes	X No
12	Is this a defined contribution plan subject to the minimum funding			or se	ection	3U∠ Of	EKISA!	168	\ INO
a	If a waiver of the minimum funding standard for a prior year is being	(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						ing	
If	you completed line 12a, complete lines 3, 9, and 10 of Schedule					Day	Y	ear	
	Enter the minimum required contribution for this plan year					12b			
	Enter the minimum required contribution for this plan year						<u> </u>		

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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 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?	X	res 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	X Yes	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):	13c(2) E	IN(s)	13c(3)	PN(s)
Part	VIII Trust Information (optional)				

14b Trust's EIN

14a Name of trust

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Short Form Annual Return/Report of Small Employee Benefit Plan

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OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation Complete all entries in accordance with the instructions to the Form 5500-SF.								
Part Annual Report Identification Information								
For calendar plan year 2012 or fiscal plan year beginning	01/01/2012	and ending	12/31/2012					
A This return/report is for: 🗵 a single-employer plan 📗 a	. multiple-employer pl	an (not multiemployer)	a one-participant plan					
B This return/report is: The first return/report	ne final retum/report							
an amended return/report	short plan year retur	n/report (less than 12 m	onths)					
C Check box if filling under: Form 5558	utomatic extension		☐ DFVC program					
special extension (enter description))		•					
Part II Basic Plan Information — enter all requested inform		·····						
1a Name of plan		1b Three-digit	-					
ADEDDOCK OVER ATTACK AN ADDOCKE CURDING ATTAK			plan number					
ABERDEEN EYE CLINIC, PA PROFIT SHARING PLAN			(PN) ➤ 001 1C Effective date of plan					
			01/01/2004					
2a Plan sponsor's name and address; include room or suite number (er	nployer, if for a single	-employer plan)	2b Employer Identification Number	 r				
ABERDEEN EYE CLINIC, PA			(EIN) 20-1593875					
			2c Sponsor's telephone number					
P.O. BOX 955		!	(662) 369-2444					
			2d Business code (see instructions 621320	s)				
3a Plan administrator's name and address X Same as Plan Sponsor	Name [] Same as I	Han Spanger Address						
va rian administrators flattle and address [25] dailte as Fian oponson	Hattle [Oattle as I	-iaii Sponsor Address	3b Administrator's EIN					
			7- 4					
			3c Administrator's telephone numb	er				
4 If the name and/or EiN of the plan sponsor has changed since the laname, EIN, and the plan number from the last return/report.	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 8					
b Total number of participants at the end of the plan year	**********************		5b 0	Harry				
Number of participants with account balances as of the end of the p- complete this item)	an year (defined ben	efit plans do not	5c 0					
6a Were all of the plan's assets during the plan year invested in eligible	assets? (See instruc	tions.)	∑Yes □	No				
b Are you claiming a waiver of the annual examination and report of a		ed public accountant (IQI	PA)					
under 29 CFR 2520.104-46? (See instructions on waiver eligibility a	- 1100-40		XYes □	No				
If you answered "No" to either line 6a or line 6b, the plan canno								
Caution: A penalty for the late or incomplete filing of this return/rep								
Under penalties of perjury and other penalties set forth in the instruction SB or Schedule MB completed and signed by an enrolled actuary, as we	s, I declare that I hav	e examined this return/re	port, including, if applicable, a Schedu	ule				
belief, it is true, correct, and complete.	an as are electrolise at	sision or any return repor	L and to the best of my knowledge an	10				
SIGN Man (- La planning	7-23-12	DR. CONNIE LONG	•					
HERE Signature of plan administrator	Date		ual signing as plan administrator					
質量を表する /	Date		a signing as plan administrator					
HERE Signature of employer/plansponsor	Date	DR. CONNIE LONG						
Preparer's name (including firm name, if applicable) and address; include	per (optional)	al signing as employer or plan sponsor Preparer's telephone number (option						
I .	ya o. yaka pana	Johnson	(985) 792-0771	icalj				
389 HIGHWAY 21	ADVANTAGE NETWORK FINANCIAL SVCS 389 HIGHWAY 21							
SUITE 401								
				開脫				
US MADISONVILLE LA 70447		MH)						

Par	illi Financial Information				****				
	n Assets and Liabilities (a) Beginning of			ar (b) End of Year					
a 7	otal plan assets	7a	108,34	8					0
<u>b 7</u>	otal pian liabilities	7b_							0
CN	let plan assets (subtract line 7b from line 7a)	7c	108,34	8				0	
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total				
	Contributions received or receivable from: 1) Employers	8a(1)	1,92	· A	**************************************				
	2) Participants	8a(2)		. 78	SCHOOL				
	3) Others (including rollovers)	8a(3)		13/54	が1962年1963年 1868年日1963年 1868年日1963年				
	Other income (loss)	8b	0	1000				AUGUSELLAS, AU	
	otal income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							
d E	Senefits paid (including direct rollovers and insurance premiums		29 cm 25 cm, sandratous seasth the outsite or all supp	Santair)	acent	Kerielus	11.18.41975.1517.1812.	ericoloreu. Desirioloreu	L,924
	provide benefits)	8d	110,27	2			化排送物料		
•	Pertain deemed and/or corrective distributions (see instructions)				###	建筑	8個/跨東漢	源學院	那期間即影响
<u>f</u> /	dministrative service providers (salaries, fees, commissions)	. 8f			影響	100 联动		理學與	建筑的学生
g	Other expenses	. 8g			熟訊				湖海湖流
	otal expenses (add lines 8d, 8e, 8f, and 8g)	. 8h	电器加速加速 加速 1 点: 后来发生		<u> </u>			110	272
	let income (loss) (subtract line 8h from line 8c)	. 8i							,348)
	ransfers to (from) the plan (see instructions)	. <u>8j</u>			棚機				
Pai	tilV Plan Characteristics								
bı	9a 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 feature codes from the List of Plan Characteristic Codes in the instructions:								
	tV Compliance Questions								
10	3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -					No	A	unount	t
a Was there a failure to transmit to the plan any participant contributions w 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Co			ection Program)	10a		x			
	Were there any nonexempt transactions with any party-in-interest on line 10a.)		***************************************	10b		x			
	Was the plan covered by a fidelity bond?			10c	x				10,000
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?		***************************************	10d		x			
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service or other organization that provides some or all instructions.)	of the ben	efits under the plan? (See	10e		×			
f	Has the plan failed to provide any benefit when due under the pla	in?	***************************************	10f		ж			***************************************
g	Did the plan have any participant loans? (If "Yes," enter amount a	as of year	end.)	10g		x			
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)			10h	·	×			
i	If 10h was answered "Yes," check the box if you either provided to exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	10i			77 7 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Par	Pension Funding Compliance				L	Ļ	Transmissing in	11312 11374	489 K8775 LT
11	Is this a defined benefit plan subject to minimum funding requirer 5500) and line 11a below)	ments? (If	"Yes," see instructions and com	plete	Sched	dule S	B (Form		/ (중기 N.
11a	Enter the amount from Schedule SB line 39					44-		<u></u> `	Yes 区 No
12	Is this a defined contribution plan subject to the minimum funding			or sec	tion 3	11a 02 of	ERISA?		res 🗵 No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below	v, as applic	;able.}						
a		ing amorti	zed in this plan year, see instruc	tions, nth			he date of t		
<u>If</u>	you completed line 12a, complete lines 3, 9, and 10 of Schedul	le MB (Fo	m 5500), and skip to line 13.						
	Enter the minimum required contribution for this plan year			*******		125			
									······································

	Form 5500-SF 2012 Page 3-				
					_
<u>C</u>	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 in any plan year?	X Y	es 🔲 t	4 0	_
	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 ☐ No	
c	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.)	0			
- 1	3c(1) Name of plan(s): 13	(2) EIN	(s)	13c(3) PN(s)	_
Part	Trust Information (optional)				
14a Name of trust				ų.	
		1			

5500-SF Electronic Filing Authorization

Plan Name: ABERDEEN EYE CLINIC, PA PROFIT SHARING PLAN

EIN/PN: 20-1593875/001

Plan Year: 01/01/2012 - 12/31/2012

I hereby authorize Advantage Network Financial Services, LLC to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500-SF for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator

Plan Sponsor

7-23-13

(sign) Carm Cay

(date)