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.

1210-0089

OMB Nos. 1210-0110

2013

This Form is Open to Public Inspection

	rt I		t Identification Informa	tion						
For	For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013									
A T	his retu	urn/report is for:	X a single-employer plan	а	multiple-employer pl	an (not multiemployer)		a one-partici	pant plan	
ВТ	his retu	urn/report is:	the first return/report	tr	ne final return/report					
			an amended return/repo	ort a	short plan year returr	n/report (less than 12 m	onths)		
C	Check b	ox if filing under:	Form 5558	а	utomatic extension			DFVC progra	am	
			special extension (enter	description))					
Pa	rt II	Basic Plan Inf	ormation—enter all request	ed informati	on				_	
	Name o						1b	Three-digit		
EAR,	NOSE	& THROAT PHYS. I	N. MISS. 401K PLAN					plan number (PN) ▶	002	
							1c	Effective date of		
								07/01	/1976	
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) EAR, NOSE & THROAT PHYSICIANS OF NORTH MISSISSIPPI, P.A.								Employer Identi (EIN) 64-05	ification Number 574599	
50.	201/04						2c	Sponsor's telep		
	3OX 21 LO, MS	80 § 38803-2180					2d		(see instructions)	
								6211		
			and address Same as Plan	•	me Same as Plan	Sponsor Address	3b	Administrator's 64-05	EIN 574599	
	SIPPI,	THROAT PHYSICIA P.A.		BOX 2180 ELO, MS 38	803-2180		3с	3c Administrator's telephone numbe 662-844-7540		
								002-044	4-7340	
-										
4			he plan sponsor has changed		st return/report filed fo	or this plan, enter the	4b EIN			
а		ens, and the plan h or's name	umber from the last return/repo	ort.			4c PN			
	•		ts at the beginning of the plan	/ear			5a		51	
b	Total n	umber of participan	ts at the end of the plan year				5b		50	
С			h account balances as of the e		•	•	5c		50	
6a		,	ets during the plan year investe						X Yes No	
	Are yo	u claiming a waiver	of the annual examination and	report of an	independent qualifie	d public accountant (IQ	PA)			
			6? (See instructions on waiver either line 6a or line 6b, the						X Yes ∐ No	
c	•		efit plan, is it covered under the						Not determined	
						,	<u> </u>	<u> </u>		
			e or incomplete filing of this							
SB c	or Sche		other penalties set forth in the i and signed by an enrolled actumplete.							
SIGI	•	Filed with authorize	d/valid electronic signature.		04/21/2014	J. MONTGOMERY BE	ERRY	, MD		
HER	ĽΕ	Signature of plan	administrator		Date	Enter name of individ	ual si	gning as plan adr	ministrator	
SIGI										
HER			loyer/plan sponsor		Date	Enter name of individ				
Prep	arer's r	name (including firm	name, if applicable) and addre	ess; include	room or suite number	r (optional)	Pre	parer's telephone	number (optional)	

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Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning of Yea	ar			(b) En	d of Y	ear	
a	Total plan assets	7a	595313				()		143598	}
	Total plan liabilities	7b		0					0)
	Net plan assets (subtract line 7b from line 7a)	7c	595313	3			7143598			}
	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total			
	Contributions received or receivable from:		(a) runount				(2)	. Ota.		
	(1) Employers	8a(1)	22140	4						
	(2) Participants	8a(2)	12899	9						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b	91215	1						
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						12	262554	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	7208	9						
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							72089)
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						1	190465	;
j	Transfers to (from) the plan (see instructions)	8j								
Pai	t IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 3D	feature co	des from the List of Plan Char	acteris	stic Co	des in	the instru	uctions	3:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	es from the List of Plan Chara	cterist	ic Coc	les in t	he instruc	ctions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Am	ount	
a	Was there a failure to transmit to the plan any participant contribute 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidure)			10a		X				
b	Were there any nonexempt transactions with any party-in-interest on line 10a.)	? (Do not i	nclude transactions reported	10b		X				
	Was the plan covered by a fidelity bond?			10c	X					500000
d	Did the plan have a loss, whether or not reimbursed by the plan's	fidelity bor	nd, that was caused by fraud			X				300000
	or dishonesty?			10d						
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all	•	,			V				
	instructions.)			10e		X				
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	s of year e	nd.)	10g		X				
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										
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)							T	Yes	П No
112	Enter the unpaid minimum required contribution for current year fr					11a		· _		
12							EDIGAG	Тг	Yes	X No
12	Is this a defined contribution plan subject to the minimum funding			or se	CHON	3U∠ UT	EKIJA!.	- _	163	/ INO
a	(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 being granting the waiver.	ng amortize	ed in this plan year, see instru		, and e	_	ne date of			ing
If	you completed line 12a, complete lines 3, 9, and 10 of Schedule					Day		Yea		
	Enter the minimum required contribution for this plan year	•			[12b				

Page	3 -		1
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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?	Y	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 beneficiaries, transferred to another plan, or brought under the coof the PBGC?	ontrol 		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) to which assets or liabilities were transferred. (See instructions.))				
1	3c(1) Name of plan(s):	c(2) Ell	V(s)	13c(3) PN(s)		
Part	VIII Trust Information (optional)					
14a	Name of trust	14b Trust's EIN				

Form 5500-SF

Department of the Treasury Internal Revenue Service

Short Form Annual Return/Report of Small Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Internal Revenue Service	/ee	2013		
Department of Labor Employee Benefits Security Administration	ct of 1974 (ERISA), and sections 6057(b) and 605 ernal Revenue Code (the Code).		This Form is Open to Public	
Pension Benefit Guaranty Corporation	Complete all entries in ac	cordance with the instructions to the Form 55	00-SF.	Inspection
For calendar plan year 2013 or fisca	lentification Information	01/01/2013 and ending		
_	X a single-employer plan			12/31/2013
B This return/report is:	the first return/report	a multiple-employer plan (not multiemployer)) [a one-participant plan
inis recumreporcis.	an amended return/report	the final return/report		
C Check box if filing under:	Form 5558	a short plan year return/report (less than 12 n	поnths) г	.
Crieck box ir illing under.	special extension (enter descri	automatic extension	L	DFVC program
Part II Basic Plan Inform	<u></u>			
1a Name of plan	nation—enter all requested into	omation	46 7	
EAR, NOSE & THROAT PH	IYS. N. MISS. 401K P	LAN		Three-digit Dian number
		22.21		PN)) 002
				ffective date of plan
2a Plan enoneor's name and addre	aco: inoludo room or quito numbo	r (employer, if for a single-employer plan)		7/01/1976
EAR, NOSE & THROAT PH	YSICIANS OF NORTH M	r (employer, if for a single-employer plan) ISSISSIPPI, P.A.		Employer-Identification Number
				EIN) 64-0574599 Sponsor's telephone number
P.O. BOX 2180			6	562-844-7540
				Business code (see instructions)
TUPELO	MS 38803-2180		6	21111
Sa Plan administrator's name and a EAR, NOSE & THROAT PH	address ∐Same as Plan Sponso YSICIANS OF NORTH M:	or Name Same as Plan Sponsor Address		dministrator's EIN 54-0574599
			3c A	dministrator's telephone number
P.O. BOX 2180			6	62-844-7540
TUPELO	MS 38803-2180			
4 If the name and/or EIN of the plan	an sponsor has changed since th	ne last return/report filed for this plan, enter the	4b E	in
name, EIN, and the plan numbe a Sponsor's name	or from the last return/report.		42.5	**
	the beginning of the plan year		4c P	
			100	51
 Number of participants with according 	ount balances as of the end of th	e plan year (defined benefit plans do not	5b	50
complete this item)			5c	50
6a Were all of the plan's assets du	iring the plan year invested in elig	gible assets? (See instructions.)		X Yes No
 D Are you claiming a waiver of the 	e annual examination and report	of an independent qualified public accountant (IO	(A (A	ht —
If you answered "No" to eithe	r line 6a or line 6b, the plan car	ty and conditions.)nnot use Form 5500-SF and must instead use	Sorm Si	X Yes No
C If the plan is a defined benefit plan	an, is it covered under the PBGC	c insurance program (see ERISA section 4021)?	ΓΟΙΙΙΙ 33 Π γ	os Ohio Ohiot determined
Under penalties of periury and other	ncomplete filling of this return/r	report will be assessed unless reasonable cau	ise is es	tablished.
SB or Schedule MB completed and s belief, it is true, correct, and complete	ngheu by an enrolled actuary, as	ons, I declare that I have examined this return/rep well as the electronic version of this return/report	ort, inclu , and to t	uding, if applicable, a Schedule the best of my knowledge and
SIGN HERE		J. Montgomery	Berry	y, MD
Signature of plan admi	nistrator	Date Enter name of individu	ual signir	ng as plan administrator
SIGN /////	/	1/2///4 J. Montgomery		
HERE Signature of employer/	plan sponsor	Date Enter name of individu	ual signir	ng as employer or plan sponsor
Preparer's name (including firm name	 if applicable) and address; incli 	ude room or suite number (optional)	Prepare	er's telephone number (optional)
		ŀ	38886	

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	Form 5500-SF 2013		Page 2				
Pa	rt III Financial Information						
7	Plan Assets and Liabilities	y second	(a) Beginning of Ye	ar	T		(b) End of Year
а	Total plan assets	7a		531	33		7143598
	Total plan liabilities	7b			0		
	Net plan assets (subtract line 7b from line 7a)	7c	59	531.	33		7143598
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total
а	Contributions received or receivable from: (1) Employers	8a(1)	1	214	04	(1) (1) (2) (1) (2) (3) (4) (4)	
	(2) Participants	8a(2)	1	289	99	8	
	(3) Others (including rollovers).	8a(3)					
b	Other income (loss)	8b	9	121	51		
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					1262554
d —	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d		7208	3 9	31.50 AV 6 93. AV 64.6	
е	Certain deemed and/or corrective distributions (see instructions)	. 8e			100		
f	Administrative service providers (salaries, fees, commissions)	8f			49	0.02.13	
9	Other expenses	8g					
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					72089
i	Net income (loss) (subtract line 8h from line 8c)	81			joë:		1190465
j	Transfers to (from) the plan (see instructions)	8j			8/34/		and the second s
Pai	rt IV Plan Characteristics						
9a	If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 3D	feature co	des from the List of Plan Char	acteri	stic Co	des in	the instructions:
þ	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	es from the List of Plan Chara	cteris	tic Cod	les in t	he instructions:
Par	t V Compliance Questions					•	
10	During the plan year:				Yes	No	Amount
	Was there a failure to transmit to the plan any participant contribu 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	iciary Corr	ection Program)	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	C Was the plan covered by a fidelity bond?				Х		500000
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	
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	er persons of the ben	s by an insurance carrier, efits under the plan? (See	10e		х	

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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 5500) and line 11a below)	complete	Schedule	SB (Form	Yes No
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 3				
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the 0	Code or se	ection 302	of ERISA?	Yes X No
(If "Yes," complete line 12a or lines 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 in granting the waiver.	structions Month		r the date of ay	the letter ruling Year
If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line				
b Enter the minimum required contribution for this plan year		121		

f Has the plan failed to provide any benefit when due under the plan?

g Did the plan have any participant loans? (If "Yes," enter amount as of year end.).....

If 10h was answered "Yes," check the box if you either provided the required notice or one of the

h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR

	Form 5500-SF 2013		Page 3 -						
C	Enter the amount contributed by the employer to the plant	an for this plan year	***************************************		12c				
d	Subtract the amount in line 12c from the amount in line negative amount).	12b. Enter the result (er	ter a minus sign to the	left of a	12d				
e	Will the minimum funding amount reported on line 12d	be met by the funding de	eadline?			Yes	П	No [N/A
Part							<u> </u>		1
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 rever				13a				
b	Were all the plan assets distributed to participants or be of the PBGC?	eneficiaries, transferred t	o another plan, or broug	tht under the	control		П	Yes	X No
С	If during this plan year, any assets or liabilities were tra which assets or liabilities were transferred. (See instruc	ansferred from this plan to	another plan(s), ident	fy the plan(s)	to	1			100
1	3c(1) Name of plan(s):			1	3c(2) E	N(s)		13c(3)	PN(s)
								<u>) f</u>	
									<u> </u>
Part	VIII Trust Information (optional)			<u> </u>					
	lame of trust				14b Tr	ust's EIN			
				THE PARTY OF THE P					