| Form 5500-SF Short Form Annual Return/Report of Small Er  |   |  |  |  |  | OMB Nos. 1210-0110<br>1210-0089                           |  |  |  |  |
|---|---|--|--|--|--|---|--|--|--|--|
|   | tment of the Treasury<br>nal Revenue Service  | This form is required to be filed  |  | 065 of the Employee Re                                 | tirement                                   | 2016  |  |  |  |  |
| Employee Be   | partment of Labor<br>enefits Security Administration  | Income Security Act of 1974  |  | 7(b) and 6058(a) of the I                              |  | This Form is Open to<br>Public Inspection                 |  |  |  |  |
|   | nefit Guaranty Corporation  | Complete all entries in a  | ccordance with the instru  | uctions to the Form 55                                 | 00-SF.                                     |   |  |  |  |  |
| For calenda   | ar plan year 2016 or fisc   | dentification Information<br>al plan year beginning 01/01/20                         | 017  | and ending 05  | /01/2017                                   |   |  |  |  |  |
|   |   | X a single-employer plan   | a multiple-employer pla  |  | ilers checl                                | king this box must attach a                               |  |  |  |  |
| A This ret  | urn/report is for:  | a one-participant plan   | list of participating em   | ployer information in acc                              | cordance w                                 | vith the form instructions.)                              |  |  |  |  |
| <b>B</b> This retu  | ırn/report is   | the first return/report  | X the final return/report  |  |  |   |  |  |  |  |
|   | ĺ   | an amended return/report   | a short plan year return   | n/report (less than 12 mc                              | onths)                                     |   |  |  |  |  |
| C Check b   | box if filing under:  | Form 5558  | automatic extension  | ]  | DFVC p                                     | rogram  |  |  |  |  |
|   | [   | special extension (enter descri  | ption)   |  |  |   |  |  |  |  |
| Part II   | Basic Plan Infor  | mation—enter all requested info  | ormation   | F  |  | 1   |  |  |  |  |
| 1a Name<br>ANESTHESI  |   | OXFORD, PLLC PROFIT SHARII   | NG PLAN  |  | 1b Thre<br>plan<br>(PN)                    | number  |  |  |  |  |
|   |   |  |  |  | , ,  | tive date of plan   |  |  |  |  |
|   | oonsor's name (employe<br>address (include room,  |  | 12/23/1991           2b         Employer Identification Number<br>(EIN)         64-0909661 |  |  |   |  |  |  |  |
| City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>ANESTHESIA CONSULTANTS OF OXFORD, PLLC |   |  |  |  |  | <b>2c</b> Sponsor's telephone number                      |  |  |  |  |
|   |   |  |  |  |  | 662-236-1202<br>ness code (see instructions)              |  |  |  |  |
| 23 CR 3024<br>OXFORD, MS 38655  |   |  |  |  |  | 621111  |  |  |  |  |
| <b>3a</b> Plan administrator's name and address X Same as Plan Sponsor.   |   |  |  |  | 3b Administrator's EIN                     |   |  |  |  |  |
|   |   |  |  |  | <b>3c</b> Administrator's telephone number |   |  |  |  |  |
|   |   | plan sponsor has changed since t<br>ber from the last return/report.                 | he last return/report filed fo   | or this plan, enter the                                | e <b>4b</b> EIN                            |   |  |  |  |  |
| <b>a</b> Sponso   | or's name   | •  |  |  | <b>4c</b> PN                               |   |  |  |  |  |
| 5a Total r  | number of participants a  | t the beginning of the plan year   |  |  | 5a   | 7   |  |  |  |  |
|   |   | t the end of the plan year   |  |  | 5b   | 0   |  |  |  |  |
|   |   | ccount balances as of the end of t   |  |  | 5c   | 0   |  |  |  |  |
| <b>d(1)</b> Tota  | al number of active parti   | cipants at the beginning of the pla  | an year  |  | 5d(1)                                      | 0   |  |  |  |  |
|   |   | cipants at the end of the plan yea   |  |  | 5d(2)                                      | 0   |  |  |  |  |
|   |   | erminated employment during the  |  |  | 5e   | 0   |  |  |  |  |
| Caution: A  | penalty for the late or   | incomplete filing of this return   | /report will be assessed   | unless reasonable cau                                  |  |   |  |  |  |  |
| SB or Sche  | alties of perjury and othe<br>dule MB completed and<br>rue, correct, and comple   | er penalties set forth in the instruc<br>I signed by an enrolled actuary, as<br>ete. | tions, I declare that I have<br>s well as the electronic vers                              | examined this return/rep<br>sion of this return/report | ort, includi<br>, and to the               | ng, if applicable, a Schedule<br>best of my knowledge and |  |  |  |  |
| SIGN Filed with authorized/valid electronic signature. 06/14/2017 DAVID P. HUGGINS  |   |  |  |  | 1.D.                                       |   |  |  |  |  |
| HERE  | Signature of plan ad  | ministrator  | inistrator Date Enter name of individ  |  |  |   |  |  |  |  |
| SIGN<br>HERE  |   |  |  |  |  |   |  |  |  |  |
|   | Signature of employed and the second | er/plan sponsor<br>me, if applicable) and address (inc                               | Date<br>clude room or suite numbe  |  |  | as employer or plan sponsor<br>s telephone number         |  |  |  |  |
|   |   |  |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |   |  |  |  |  |

| -  | Were all of the plan's assets during the plan year invested in eligib  | •           | ,                                      |                            |
|----|--|-------------|--|----------------------------|
| b  | Are you claiming a waiver of the annual examination and report of a<br>under 29 CFR 2520.104-46? (See instructions on waiver eligibility a<br>If you answered "No" to either line 6a or line 6b, the plan cann | Yes No      |  |                            |
| С  | If the plan is a defined benefit plan, is it covered under the PBGC in   |             |  |                            |
| Pa | rt III Financial Information   |             |  |                            |
| 7  | Plan Assets and Liabilities  |             | (a) Beginning of Year                  | (b) End of Year            |
| а  | Total plan assets  | 7a          | 3370972                                | 0                          |
| b  | Total plan liabilities   | 7b          | 0                                      | 0                          |
| С  | Net plan assets (subtract line 7b from line 7a)  | 7c          | 3370972                                | 0                          |
| 8  | Income, Expenses, and Transfers for this Plan Year   |             | (a) Amount                             | (b) Total                  |
| а  | Contributions received or receivable from:<br>(1) Employers  | 8a(1)       | 0                                      |                            |
|    | (2) Participants   | 8a(2)       | 0                                      |                            |
|    | (3) Others (including rollovers)   | 8a(3)       | 0                                      |                            |
| b  | Other income (loss)  | 8b          | 182969                                 |                            |
| C  | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)   | 8c          |  | 182969                     |
| d  | Benefits paid (including direct rollovers and insurance premiums to provide benefits)  | 8d          | 3539847                                |                            |
| е  | Certain deemed and/or corrective distributions (see instructions).   | 8e          | 0                                      |                            |
| f  | Administrative service providers (salaries, fees, commissions)   | 8f          | 14094                                  |                            |
| g  | Other expenses   | 8g          | 0                                      |                            |
| h  | Total expenses (add lines 8d, 8e, 8f, and 8g)  | 8h          |  | 3553941                    |
| i  | Net income (loss) (subtract line 8h from line 8c)  | 8i          |  | -3370972                   |
| j  | Transfers to (from) the plan (see instructions)  | 8j          | 0                                      |                            |
| Pa | rt IV Plan Characteristics   |             |  |                            |
| 9a | 2A 2E 2F 2G 2J 2T 3D   |             |  |                            |
| b  | If the plan provides welfare benefits, enter the applicable welfare fe   | eature code | s from the List of Plan Characteristic | Codes in the instructions: |

## Part V Compliance Questions

| 10 | During the plan year:   |     | Yes | No | N/A | Amount |
|----|---|-----|-----|----|-----|--------|
| а  | 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 |     | х  |     |        |
| b  | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)   | 10b |     | Х  |     |        |
| С  | Was the plan covered by a fidelity bond?  | 10c | Х   |    |     | 300000 |
| 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 |     | Х  |     |        |
| 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 |     | x  |     |        |
| f  | Has the plan failed to provide any benefit when due under the plan?   | 10f |     | Х  |     |        |
| g  | Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)   | 10g |     | Х  |     |        |
| h  | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)   | 10h |     | Х  |     |        |
| 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 a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and c<br>m 5500) and line 11a below)   |          |                        |                                     |          | <u> </u>              | Yes 🗙 No  |  |  |
| 11a  | Ente     | r the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40  |          |                        | 11a                                 |          |                       |           |  |  |
| 12   |          | his a defined contribution plan subject to the minimum funding requirements of section 412 of the Co  |          |                        |                                     |          |                       | Yes 🗙 No  |  |  |
|      |          | SA?<br>Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)   |          |                        |                                     |          | ··  🖵                 |           |  |  |
| а    |          | vaiver of the minimum funding standard for a prior year is being amortized in this plan year, see inst  | tructior | is, and                | enter t                             | he date  | of the lette          | er ruling |  |  |
|      | <u> </u> | ting the waiver   |          |                        | _ Day                               | ′        | Year _                |           |  |  |
| lf   | you c    | ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1   | 13.      |                        |                                     | 1        |                       |           |  |  |
| 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    |          | ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the least of the matter 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 Ye     | s N                   | lo        |  |  |
|      | lf "Y    | es," enter the amount of any plan assets that reverted to the employer this year  |          |                        | 13a                                 |          |                       | 0         |  |  |
| b    |          | e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or broug rol of the PBGC?  |          |                        |                                     |          | X Yes                 | No        |  |  |
| C    |          | uring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi<br>th assets or liabilities were transferred. (See instructions.)                    | fy the p | olan(s)                | to                                  |          |                       |           |  |  |
| 1    | 3c(1)    | Name of plan(s):  |          | 13c(2)                 | EIN(s)                              |          | <b>13c(3)</b> PN(s)   |           |  |  |
|      |          |   |          |                        |                                     |          |                       |           |  |  |
|      |          |   |          |                        |                                     |          |                       |           |  |  |
| Part | VIII     | Trust Information   |          |                        |                                     |          |                       |           |  |  |
|      |          | of trust  |          |                        | 14b Trust's EIN                     |          |                       |           |  |  |
|      |          |   |          |                        |                                     |          |                       |           |  |  |
|      |          |   |          |                        |                                     |          |                       |           |  |  |
| 14c  | Name     | e of trustee or custodian   |          |                        | <b>14d</b> Trustee's or custodian's |          |                       |           |  |  |
|      |          |   |          |                        | telephone number                    |          |                       |           |  |  |
| Par  | LIV      | IRS Compliance Questions  |          |                        |                                     |          |                       |           |  |  |
| Fai  |          |   |          |                        |                                     |          | Π                     |           |  |  |
| 15a  | Is the   | plan a 401(k) plan? If "No," skip b   | 🛛        | Yes                    |                                     |          | No                    |           |  |  |
|      |          | did the plan satisfy the nondiscrimination requirements for employee deferrals under section<br>)(3) for the plan year? Check all that apply:   |          | Desigi<br>safe h       | n-based<br>arbor                    | 1 [      | Prior yet test        | ear" ADP  |  |  |
|      |          |   |          | "Curre<br>ADP t        | ent year'<br>est                    | 13       | N/A                   |           |  |  |
| 16a  |          | t testing method was used to satisfy the coverage requirements under section 410(b) for the plan<br>? Check all that apply:   |          | Ratio<br>perce<br>test | entage                              |          | verage<br>enefit test | N/A       |  |  |
| 16b  |          | he plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) e plan year by combining this plan with any other plan under the permissive aggregation rules? |          | Yes                    |                                     |          | No                    |           |  |  |
|      | the le   |   | -        |                        |                                     |          |                       |           |  |  |
|      | letter   |   | nter the | date o                 | of the m                            | lost rec | ent determi           | nation    |  |  |
| 18   | Were     | ed Benefit Plan or Money Purchase Pension Plan Only:<br>any distributions made during the plan year to an employee who attained age 62 and had not sepa<br>ce?                                  |          | rom                    | Yes                                 | s [      | No                    |           |  |  |
| 19   | Was      | any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?  |          |                        | Yes                                 | s        | No                    |           |  |  |

|  | 1  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
|--|--|---------------------------------------|-------------|--------------------|-----------------------------------|---------------------------|---|-----------------------------------|--------------------------------------|--|--|--|
| Form 5500-SF Short Form Annual Return/Report of Small Emp<br>Department of the Treasury Benefit Plan   |  |                                       |             |                    |                                   |                           | e   | OMB Nos. 1210-0110<br>1210-0089   |                                      |  |  |  |
| Internal Revenue Service   | This form is required to be filed under sections 104 and 4065 of the Employe<br>Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6056 |                                       |             |                    |                                   |                           |   | 2016                              |                                      |  |  |  |
| Department of Labor<br>Employee Benefits Security Administration   |  | ternal Reven                          |             |                    |                                   | nd 6058(a                 | a) of   | This Form is Open to Public       |                                      |  |  |  |
| Pension Benefit Guaranty Corporation   | ► Complete all entries in acc  | cordance wi                           | th the in   | struct             | ions to the Fo                    | orm 5500-                 | SF.   |                                   | spection                             |  |  |  |
|  | dentification Information  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
| For calendar plan year 2016 or fisc  |  |                                       | 01/201      |                    | and ending                        | T                         |   | 01/2017                           |                                      |  |  |  |
| A This return/report is for:   | x a single-employer plan   | a multipl<br>a list of p<br>a foreigr | participat  | /er plai<br>ing em | n (not multiem)<br>ployer informa | ployer) (F<br>ition in ac | ilers ch<br>cordanc                               | ecking this bo<br>ce with the for | ox must attach<br>rm instructions.)  |  |  |  |
| B This return/report is:   | the first return/report<br>an amended return/report  | x the final                           |             | •                  | /report (less that                | an 12 moi                 | nths)   |                                   |                                      |  |  |  |
| C Check box if filing under:   | Form 5558  | automat                               | ic extens   | ion                |                                   |                           |   | DFVC progra                       | ım                                   |  |  |  |
|  | special extension (enter descri  | ption)                                |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
| Part II Basic Plan Inform  | mation enter all requested in  | nformation                            |             |                    |                                   |                           |   |                                   | *********                            |  |  |  |
| 1a Name of plan<br>ANESTHESIA CONSULTANTS OF OXFORD, PLLC PROFIT SHARING PLAN  |  |                                       |             |                    |                                   |                           | pla   | ree-digit<br>an number<br>N) ►    | 001                                  |  |  |  |
|  |  |                                       |             |                    |                                   |                           | 1c Ef   | fective date o                    |                                      |  |  |  |
| <ul> <li>Plan sponsor's name (employer, if for a single-employer plan)<br/>Mailing Address (include room, apt., suite no. and street, or P.O. Box)</li> </ul>  |  |                                       |             |                    |                                   |                           |   | 2/23/1991<br>nployer Identi       | fication Number                      |  |  |  |
| City or town, state or province,<br>ANESTHESIA CONSULTAN   | country, and ZIP or foreign posta  | al code (if for                       | eign, see   | instru             | ctions)                           | -                         | (EIN) 64-0909661<br>2c Sponsor's telephone number |                                   |                                      |  |  |  |
|  |  |                                       |             |                    |                                   |                           | (662) 236-1202                                    |                                   |                                      |  |  |  |
| 23 CR 3024   |  |                                       |             |                    |                                   |                           | 2d Business code (see instructions)<br>621111     |                                   |                                      |  |  |  |
| US OXFORD MS 38655<br>3a Plan administrator's name and   |  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
|  |  |                                       |             |                    |                                   |                           |   | ministrator's                     | telephone number                     |  |  |  |
|  |  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
| 4 If the name and/or EIN of the p<br>name, EIN, and the plan numb  | olan sponsor has changed since t<br>er from the last return/report.  | he last returr                        | n/report fi | led for            | this plan, ente                   | er the                    | 4b Ell  | N                                 |                                      |  |  |  |
| a Sponsor's name   |  |                                       |             |                    |                                   |                           | 4c PN   |                                   |                                      |  |  |  |
| 5a Total number of participants at   |  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |
| <b>b</b> Total number of participants at   | the end of the plan year   |                                       |             |                    |                                   | ·····                     | 5b  |                                   | 0                                    |  |  |  |
| C Number of participants with accomplete this item)  | count balances as of the end of the  | ne plan year                          | (only def   | ined co            | ontribution plan                  | ns                        | 5c  |                                   | 0                                    |  |  |  |
| d(1) Total number of active partic   |  |                                       |             |                    |                                   |                           | 5d(1)   | 1                                 | 0                                    |  |  |  |
| d(2) Total number of active partic   | ipants at the end of the plan year   | ***********                           | *****       |                    | *****                             |                           | 5d(2)   |                                   | 0                                    |  |  |  |
|  | minated employment during the p  | •                                     |             |                    |                                   |                           | 5e  |                                   | 0                                    |  |  |  |
| Caution: A penalty for the late or   | incomplete filing of this return   | /report will                          | be asses    | ssed u             | nless reasona                     | able caus                 | e is es   | tablished                         | <u> </u>                             |  |  |  |
| Under penalties of perjury and other<br>SB or Schedule MB completed and<br>belief, it is true, correct, and completed  | er penalties set forth in the instruc<br>I signed by an enrolled actuary, a  | tions. I decla                        | are that I  | have e             | examined this r                   | eturn/rend                | ort inclu   | idina if appli                    | cable, a Schedule<br>y knowledge and |  |  |  |
| SIGN MAC   | ·  |                                       |             |                    | While P                           | Hur                       | 31100   | IND                               |                                      |  |  |  |
| HERE Signature of plan admin   | istrator   | Date                                  | 川中          | ΓE                 | inter name of it                  |                           |   |                                   | nistrator                            |  |  |  |
| HERE     Signature of plan administrator     Date()   4   / Enter name of individual/eigning as plan administrator       SIGN     SIGN     Date()   4   / Enter name of individual/eigning as plan administrator |  |                                       |             |                    |                                   |                           |   |                                   | ·                                    |  |  |  |
| HERE Signature of employer/p   | lan sponsor  | Date /                                | 141         | E                  | nter name of i                    | ·                         | $\langle \rightarrow \rightarrow \rangle$         | as employer                       | or plan sponsor                      |  |  |  |
| Preparer's name (including)firm nar<br>Skip this question  | me, if applicable) and address (in   | clude room o                          | 5r şuite n  | umber              | )                                 | F                         | repare  | 's telephone<br>his questi        | number                               |  |  |  |
|  | tice see the instructions for E  |                                       |             |                    |                                   |                           |   |                                   |                                      |  |  |  |

|          | Form 5500-SF 2016  |   | Page 2                     |               |          | -     |           |         |           |               |
|----------|--|---|----------------------------|---------------|----------|-------|-----------|---------|-----------|---------------|
| 6a       | Were all of the plan's assets during the plan year invested in eligible  | e assets?   | (See instructions.)        |               | ******   |       | ********  |         | X Y       | ′es ∏No       |
| b        | Are you claiming a waiver of the annual examination and report of a  | in indepen  | dent qualified public acco | untar         | it (IQF  | PA)   |           |         |           | []            |
|          | under 29 CFR 2520.104-46? (See instructions on waiver eligibility a  | nd condition  | ons.)                      | ********      | ******** |       |           | ******* | XY        | es 🔲 No       |
|          | If you answered "No" to either line 6a or line 6b, the plan canno  |   |                            |               |          |       |           |         |           |               |
| C        | If the plan is a defined benefit plan, is it covered under the PBGC in   | surance p   | rogram (see ERISA sectio   | on 40         | 21)?     |       | Yes       |         | No 🗌 N    | ot determined |
| P        | art III Financial Information  |   |                            |               |          |       |           |         |           |               |
| 7        | Plan Assets and Liabilities  |   | (a) Beginning o            | f Yea         | r        |       |           | (b) E   | nd of Yea | r             |
| a        | Total plan assets  | 7a  | 3,37                       | 70,9          | 72       |       |           |         |           | 0             |
| b        | Total plan liabilities   | 7b  |                            |               | 0        |       |           |         |           | 0             |
| <u>C</u> | Net plan assets (subtract line 7b from line 7a)  | 7c  | 3,37                       |               | 72       |       |           |         |           | 0             |
| 8<br>a   | Income, Expenses, and Transfers for this Plan Year<br>Contributions received or receivable from:   |   | (a) Amount                 | (a) Amount    |          |       |           | ()      | b) Total  |               |
| Ģ        | (1) Employers  | 8a(1)   |                            |               | 0        |       |           |         |           |               |
|          | (2) Participants   | 8a(2)   |                            |               | 0        |       |           |         |           |               |
|          | (3) Others (including rollovers)   | 8a(3)   |                            |               | 0        |       |           |         |           |               |
| b        |  | 8b  | 18                         | 32,9          | 69       |       |           |         |           |               |
| С        | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)   | 8c  |                            |               |          |       |           |         | 1         | 82,969        |
| d        | Benefits paid (including direct rollovers and insurance premiums to provide benefits)  | 8d  | 3,53                       | 39,8          | 47       |       |           |         |           |               |
| e        | Certain deemed and/or corrective distributions (see instructions)  | 8e  |                            |               | 0        |       |           |         |           |               |
| f        | Administrative service providers (salaries, fees, commissions)   | 8f  | 1                          | L <b>4</b> ,0 | 94       |       |           |         |           |               |
| g        | Other expenses   | 8g  |                            |               | 0        |       |           |         |           |               |
| h        | Total expenses (add lines 8d, 8e, 8f, and 8g)  | 8h  |                            |               |          |       |           |         | 3,5!      | 53,941        |
| <u>i</u> | Net income (loss) (subtract line 8h from line 8c)  | <b>8</b> i  |                            |               |          |       |           |         | (3,37)    | 0,972)        |
| j        | Transfers to (from) the plan (see instructions)  | 8j  |                            |               | 0        |       |           |         |           |               |
| P        | art IV Plan Characteristics  |   |                            |               |          |       |           |         |           |               |
| 9a       | If the plan provides pension benefits, enter the applicable pension fe   | eature cod  | es from the List of Plan C | harac         | teristi  | c Coc | les in th | ie inst | ructions: |               |
|          | 2A 2E 2F 2G 2J 2T 3D   |   |                            |               |          |       |           |         |           |               |
| b        | If the plan provides welfare benefits, enter the applicable welfare fea  | ture code   | s from the List of Plan Ch | aract         | eristic  | Code  | s in the  | instru  | ictions:  |               |
|          |  |   |                            |               |          |       |           |         |           |               |
| 0        | Int V Compliance Questions   |   |                            |               |          |       |           |         |           |               |
|          | During the plan year:<br>Was there a failure to transmit to the plan any participant contribut   | tione within  | a the time period          |               | Yes      | No    | N/A       |         | Amou      | nt            |
| -        | described in 29 CFR 2510.3-102? (See instructions and DOL's Vo   |   |                            |               |          |       |           |         |           |               |
|          | Program)   |   |                            | 10a           |          | x     |           |         |           |               |
| b        | Were there any nonexempt transactions with any party-in-interest' reported on line 10a.)   | ? (Do not i   | nclude transactions        | 10b           |          | x     |           |         |           |               |
| C        | Was the plan covered by a fidelity bond?   |   |                            | 10c           | x        |       |           |         |           | 300,000       |
| d        |  | ve a loss, whether or not reimbursed by the plan's fidelity bond, that was caused |                            |               |          | x     |           |         | · · · ·   |               |
| e        | Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.) | e or all of t   | the benefits under         | 10e           |          | x     |           |         |           |               |
| f        |  |   |                            | 10f           |          | x     |           |         |           |               |
| g        |  |   |                            | 10g           |          | x     |           |         |           |               |
| h        | If this is an individual account plan, was there a blackout period? (<br>2520.101-3.)  |   |                            | 10h           |          | x     |           |         |           |               |

10i

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

i

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|      |  |                                       |                      |   |                |  | ·····    |  |
|------|--|---------------------------------------|----------------------|---|----------------|--|----------|--|
| Par  |  |                                       |                      |   |                |  |          |  |
| 11   | Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and (Form 5500 and line 11a below)   | complete                              | e Schedul            | e SB  |                | Yes [                                  | X No     |  |
|      | a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40   |                                       | 11a                  |   |                |  |          |  |
| 12   | Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the ERISA?   | Code or s                             | ection 30            | 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  | nstruction:<br>onth                   | _                    | er the da<br>av                             | te of th       |  | ruling   |  |
| If y | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line   | 13.                                   |                      | <u> </u>                                    | ·····          |  | <u></u>  |  |
| b    | Enter the minimum required contribution for this plan year   | *****                                 | . 12b                |   |                |  |          |  |
| c    | Enter the amount contributed by the employer to the plan for the plan year   |                                       |                      |   |                |  |          |  |
| d    | Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to th negative amount)   | e left of a                           | . 12d                |   |                |  |          |  |
| е    | Will the minimum funding amount reported on line 12d be met by the funding deadline?   | ******                                |                      | Yes   | ] No           |  | ν/A      |  |
| Par  | VII Plan Terminations and Transfers of Assets  |                                       |                      |   |                | ······································ |          |  |
| _13a | Has a resolution to terminate the plan been adopted in any plan year?  |                                       | .   [                | XX Yes                                      |                | No                                     |          |  |
|      | If "Yes," enter the amount of any plan assets that reverted to the employer this year  |                                       |                      | <u></u>                                     |                | (                                      |          |  |
| b    | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or broucontrol of the PBGC?  | the                                   | x                    | Yes   |                |  |          |  |
| C    | If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), iden which assets or liabilities were transferred. (See instructions.)                            | tify the pla                          | an(s) to             |   |                |  |          |  |
| 1    | 3c(1) Name of plan(s):   | 13c(2)                                | EIN(s)               | I   | 13             | 13c(3) PN(s)                           |          |  |
| Dar  | VIII Trust Information - Skip These Questions  |                                       |                      |   |                |  |          |  |
|      |  |                                       |                      |   |                |  |          |  |
| 148  | Name of trust  |                                       | 14b                  | Trust's E                                   | IN             |  |          |  |
| 140  | Name of trustee or custodian   |                                       |                      | 14d Trustee or custodian's telephone number |                |  |          |  |
| Рал  | IX IRS Compliance Questions - Skip These Questions   | · · · · · · · · · · · · · · · · · · · |                      | · · · · · · · · · · · · · · · · · · ·       |                |  |          |  |
|      | Is the plan a 401(k) plan? If "No," skip b.  |                                       | Yes                  |   |                | No                                     |          |  |
| 15b  | How did the plan satisfy the nondiscrimination requirements for employee deferrals under section   |                                       | Design-b             | anad  |                |  |          |  |
|      | 401(k)(3) for the plan year? Check all that apply:   |                                       | safe harb            |   |                | test                                   | ear" ADP |  |
|      |  |                                       | "Current<br>ADP test |   |                | N/A                                    |          |  |
| 16a  | What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:  |                                       | Ratio<br>percentag   |   | Avera<br>benef |  | □ N/A    |  |
| 16b  | Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules? |                                       | Yes                  |   |                | No                                     |          |  |
| 17a  | If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IR: the letter/ and serial number  |                                       | letter or a          | dvisory le                                  | etter, er      | iter the                               | date of  |  |
| 17b  | If the plan is an individually-designed plan that received a favorable determination letter from the IRS, letter   | enter the o                           | tate of the          | e most re                                   | cent de        | termina                                | tion     |  |
| 18   | Defined Benefit Plan or Money Purchase Pension Plan Only:<br>Were any distributions made during the plan year to an employee who attained age 62 and had not se<br>service?                                | parated fr                            | om [                 | ] Yes                                       |                | No                                     |          |  |
| 19   | Was any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?   | ******                                |                      | Yes   |                | No                                     |          |  |