

<div>Form 5500-SF</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>		<div>Short Form Annual Return/Report of Small Employee Benefit Plan</div> <div>This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</div>		<div>OMB Nos. 1210-0110 1210-0089</div> <div>2009</div> <div>This Form is Open to Public Inspection</div>	
Part I Annual Report Identification Information					
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009					
A This return/report is for:		<input checked="" type="checkbox"/> single-employer plan		<input type="checkbox"/> multiple-employer plan (not multiemployer)	
B This return/report is for:		<input type="checkbox"/> first return/report		<input type="checkbox"/> final return/report	
		<input type="checkbox"/> an amended return/report		<input type="checkbox"/> short plan year return/report (less than 12 months)	
C Check box if filing under:		<input type="checkbox"/> Form 5558		<input type="checkbox"/> automatic extension	
		<input type="checkbox"/> special extension (enter description)		<input type="checkbox"/> DFVC program	
Part II Basic Plan Information—enter all requested information					
1a Name of plan			1b Three-digit plan number (PN) ▶		001
C ROSS SIMONDS DDS PS 401K PROFIT SHARING PLAN AND			1c Effective date of plan		01/01/2001
2a Plan sponsor's name and address (employer, if for single-employer plan)			2b Employer Identification Number (EIN)		91-1990852
C ROSS SIMONDS DDS, PS LIBERTY LAKE DENTAL CARE 22106 E COUNTRY VISTA DR SUITE D LIBERTY LAKE, WA 99019			2c Plan sponsor's telephone number		509-893-1119
			2d Business code (see instructions)		621210
3a Plan administrator's name and address (if same as Plan sponsor, enter "Same")			3b Administrator's EIN		91-1990852
C ROSS SIMONDS DDS, PS 22106 E COUNTRY VISTA DR SUITE D LIBERTY LAKE, WA 99019			3c Administrator's telephone number		509-893-1119
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. Sponsor's name			4b EIN		
			4c PN		
5a Total number of participants at the beginning of the plan year			5a		7
b Total number of participants at the end of the plan year			5b		6
c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)			5c		7
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)			<input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)			<input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No
If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.					
Part III Financial Information					
7 Plan Assets and Liabilities		(a) Beginning of Year		(b) End of Year	
a Total plan assets	7a	459857		671201	
b Total plan liabilities	7b				
c Net plan assets (subtract line 7b from line 7a)	7c	459857		671201	
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total	
a Contributions received or receivable from:					
(1) Employers	8a(1)	14286			
(2) Participants	8a(2)	38527			
(3) Others (including rollovers)	8a(3)				
b Other income (loss)	8b	158531			
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			211344	
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d				
e Certain deemed and/or corrective distributions (see instructions)	8e				
f Administrative service providers (salaries, fees, commissions)	8f				
g Other expenses	8g				
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				
i Net income (loss) (subtract line 8h from line 8c)	8i			211344	
j Transfers to (from) the plan (see instructions)	8j				

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500-SF.

Form 5500-SF (2009)
v.092308.1

Part IV Plan Characteristics**9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

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:**Part V Compliance Questions**

10	During the plan year:	Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)		X	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)		X	
c	Was the plan covered by a fidelity bond?	X		75000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
e	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)		X	
f	Has the plan failed to provide any benefit when due under the plan?		X	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	X		3415
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		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		X	

Part VI Pension Funding Compliance

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

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .. ☐ Yes ☒ No
(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year	12b	
c Enter the amount contributed by the employer to the plan for this plan year	12c	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d	

e Will the minimum funding amount reported on line 12d be met by the funding deadline? ☐ Yes ☐ No ☐ N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted during the plan year or any prior year? ☐ Yes ☒ 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 control of the PBGC? ☐ Yes ☒ No

c If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/18/2010	C ROSS SIMONDS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/18/2010	C ROSS SIMONDS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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Part II Basic Plan Information - enter all requested information			
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		1c	Effective date of plan
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2a	Plan sponsor's name and address (employer, if for single-employer plan)	2b	Employer Identification Number (EIN)
	C ROSS SIMONDS DDS, PS		91-1990852
	LIBERTY LAKE DENTAL CARE	2c	Plan sponsor's telephone number
	22106 E COUNTRY VISTA DR; SUITE D		509-893-1119
		2d	Business code (see instructions)
			621210
3a	Plan administrator's name and address (If same as Plan sponsor, enter "Same")	3b	Administrator's EIN
	SAME		
		3c	Administrator's telephone number
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		4c	PN
5a	Total number of participants at the beginning of the plan year	5a	7
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b	Other income (loss) SEE STATEMENT 1	8b	158531
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	211344
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	
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Part V Compliance Questions

	Yes	No	Amount
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b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)		X	
c Was the plan covered by a fidelity bond?	X		75000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)		X	
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SIGN HERE		07/08/2010	C ROSS SIMONDS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		07/08/2010	C ROSS SIMONDS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor