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 section 6058(a) of the Internal Revenue Code (the Code).

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

2009

Inspection

This Form is Open to Public

OMB Nos. 1210-0110

1210-0089

			Identification Informatio								
For	calendar plai	n year 2009 or fis	cal plan year beginning 01/0	1/2009	and ending	12/31/2	2009				
Α	This return/report is for: Single-employer plan multiple-employer plan (not multiemployer)						one-participant plan				
	This return/re	•	first return/report	X final retu	urn/report						
_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	an amended return/report	Short nla	an year return/report (less than 12 m	onths)					
_			<u> </u>	=		10111113)	П регую				
C	Check box if	filing under:	Form 5558	automat	tic extension		DFVC program				
			special extension (enter des	scription)							
Pa	art II Ba	sic Plan Info	rmation—enter all requested i	nformation							
1a	Name of pla	ın				1b	Three-digit				
THO	MAS M. LYO	NS, DMD, PA PF	ROFIT SHARING 401(K) PLAN 8	& TRUST			plan number 001				
						_	(PN) 🕨				
						1C	Effective date of plan 01/01/2002				
20	Diamana		dana dana dana dana dana dana dana dana	-1		26		_			
		ors name and add ONS, DMD, PA	dress (employer, if for single-em	ployer plan)		20	Employer Identification Numbe (EIN) 59-3639025	Γ			
1110	MAO M. LTO	NO, DIND, I A				2c	Plan sponsor's telephone numb	her			
3298	SUMMIT BL	.VD					850-438-1777				
	E 39 SACOLA, FL	22502				2d	Business code (see instructions	s)			
							621210				
		strator's name an NS, DMD, PA	d address (if same as Plan spor	isor, enter "San SUMMIT BLVD	ne")	3b	Administrator's EIN 59-3639025				
1110	IVIAS IVI. LTO	NO, DIVID, FA	SUITE	39		30	Administrator's telephone number				
			PENSA	ACOLA, FL 325	503		850-438-1777	OCI			
4	f the name ar	nd/or EIN of the p	olan sponsor has changed since	the last return/	report filed for this plan, enter the	4b	EIN				
	name, EIN, a	and the plan numb	per from the last return/report. S	ponsor's name							
							C PN				
5a	Total number	er of participants	at the beginning of the plan year	·		<u>5а</u>					
b	Total number	er of participants	at the end of the plan year			5b		0			
С				•	year (defined benefit plans do not			0			
	· · · · · · · · · · · · · · · · · · ·	•				5c		0			
				-	? (See instructions.)		X Yes	No			
b					endent qualified public accountant (litions.)		X Yes	No			
			•	•	0-SF and must instead use Form						
Pa		nancial Inforn									
7	Plan Assets	and Liabilities			(a) Beginning of Year		(b) End of Year				
а				7a	2134	87	(0) = 110 01 100	0			
b	•					0					
C	•		7b from line 7a)		2134	_		0			
			sfers for this Plan Year			01	(b) Total				
8 a	· •	penses, and Tran ns received or rec			(a) Amount		(b) Total				
u				8a(1)		0					
	(2) Particip	ants		8a(2)							
	(3) Others ((includina rollove	rs)								
b	• •					0					
С		,), 8a(2), 8a(3), and 8b)					0			
d											
-	Benefits bai	id (including direc		ıms							
		` .	t rollovers and insurance premit		2134	87					
е	to provide b	enefits)	t rollovers and insurance premiu	8d	2134	87					
e f	to provide b Certain dee	enefits) emed and/or corre	t rollovers and insurance premiu	8d ons) 8e	2134	87					
f	to provide b Certain dee Administrati	enefits)emed and/or corre	et rollovers and insurance premiu	8d spns) 8e 8f	2134	87					
f g	to provide b Certain dee Administrati Other exper	penefits) emed and/or corre ive service provid nses	t rollovers and insurance premiu	8d sins) 8e sf sg	2134	87	213	487			
f	to provide b Certain dee Administrati Other exper Total expen	penefits) med and/or corre ive service provid nses sses (add lines 8d	et rollovers and insurance premiu ective distributions (see instruction ers (salaries, fees, commissions l, 8e, 8f, and 8g)	8d sns) 8e sh sf sg 8h	2134	87	213 -213				
f g	to provide b Certain dee Administrati Other exper Total expen Net income	penefits) med and/or corre ive service provid nses ses (add lines 8d (loss) (subtract li	t rollovers and insurance premiu	8d 8e si) 8f 8g 8h 8i	2134	87	213 -213				

Form 5500-SF 2009 Page 2- 1	Page 2- 1
-------------------------------------	------------------

Part IV	Plan	Chara	cteristics
railiv	- гіан	Gilaia	riensiirs

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

If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part	•								
10	During the plan year:		Yes	No		Amou	ınt		
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		X					
С	C Was the plan covered by a fidelity bond?								
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		X					
f	Has the plan failed to provide any benefit when due under the plan?	10f		X					
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10q		X					
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h							
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 this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 5500))						Yes	X No	
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code					_=		X No	
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)							_	
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instru granting the waiver								
lf y	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					
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 negative amount)			12d					
<u>e</u>	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?		<u>.</u>			X	Yes	No	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year			13a				0	
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought of the PBGC?	under	the co	ntrol		X	Yes	No	
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify t which assets or liabilities were transferred. (See instructions.)	he pla	n(s) to	1					
	3c(1) Name of plan(s):		13	c(2) EI	N(s)	13	3c(3)	PN(s)	
PENS	SACOLA ENDODONTICS, LLC	20-	24859	50			001	l	
Cauti	ion: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonab	le cau	ıse is	establ	ished.				
Unde	er penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this ret r Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return.	urn/re	oort, in	cluding	g, if applica				

SIGN	Filed with authorized/valid electronic signature.	10/15/2010	THOMAS M. LYONS, DMD				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN	Filed with authorized/valid electronic signature.	10/15/2010	THOMAS M. LYONS, DMD				
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor				

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 section 6058(a) of the Internal Revenue Code (the Code).

Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2009

This Form is Open to Public Inspection.

=	art Annual Report Identification Information							
	the calendar plan year 2009 or fiscal plan year beginning	01/0	1/2009	and ending	10	/31/2009		
_	This return/report is for: x single-employer plan			ot multiemployer)	<u></u>	1		
_		·		or muniemployer)	L	one-participant plan		
ט		final return	•					
_	an amended return/report	·	•	ort (less than 12 month	s) -	-		
C	Check box if filing under: X Form 5558	automatic	extension		L	DFVC program		
	special extension (enter description)							
	art II Basic Plan Information enter all requested inform	nation.						
та	Name of plan					Three-digit Dian number		
	THOMAS M. LYONS, DMD, PA PROFIT SHARING 401(k) PLAN	& TRUST			(PN) ► 001		
						Effective date of plan		
2a	Plan sponsor's name and address (employer, if for single-employer plan	-1				01/01/2002		
	THOMAS M. LYONS, DMD, PA	''				Employer Identification Number (EIN) 59-3639025		
					2c F	Plan sponsor's telephone number		
	3298 SUMMIT BLVD SUITE 39					(850) 438-1777		
	PENSACOLA FL 32503					Business code (see instructions) 521210		
3а	Plan administrator's name and address (If same as plan employer, enter	r "Same")				Administrator's EIN		
	Same							
					3c Administrator's telephone number			
4	If the name and/or EIN of the plan sponsor has changed since the last	return/repo	rt filed for this p	lan, enter the	4b 6	=1N		
	name, EIN and the plan number from the last return. Sponsor's Name				4c F	PN		
5a	Total number of participants at the beginning of the plan year				5a	5		
b	Total number of participants at the end of the plan year				5b	0		
С	Total number of participants with account balances as of the end of the	plan year (defined benefit	plans do not				
62	complete this item)		• • • • •		5c			
b	Were all of the plan's assets during the plan year invested in eligible as: Are you claiming a waiver of the annual examination and report of an in			Tagger (100A)	• •	X Yes No		
-	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and	conditions.))			X Yes No		
	If you answered "No" to either 6a or 6b, the plan cannot use Form	5500-SF a	nd must inste	ad use Form 5500.				
	rt III Financial Information	T						
7	Plan Assets and Liabilities		(a) Be	ginning of Year		(b) End of Year		
a	Total plan assets	7a		213,487		0		
b	Total plan liabilities	7b		0				
<u>c</u>	Net plan assets (subtract line 7b from line 7a)	7c		213,487		0		
8	Income, Expenses, and Transfers for this Plan Year	100011000110001000100010000000000000000	(a) Amount		(b) Total		
а	Contributions received or receivable from: (1) Employers	0-141		0	1,000 to 100 to			
	(2) Participants	8a(1) 8a(2)		<u> </u>	2000			
	(3) Others (including rollovers)	8a(2)						
b	Other income (loss)	8b		0	100000000000000000000000000000000000000			
C	Total income(add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			# # # # # # # # # # # # # # # # # # #	0		
d	Benefits paid (including direct rollovers and insurance premiums		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		200 V 2 - 200 200 V 2 - 200 20			
	to provide benefits)	8d		213,487	20000000 200000000			
e	Certain deemed and/or corrective distributions (see instructions)	8e						
f	Administrative service providers (salaries, fees, commissions)	8f			10 10 10 10 10 10 10 10 10 10 10 10 10 1			
g	Other expenses	8g	A Service of the contract of		20000			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			100	213,487		
Ĭ	Net income (loss) (subject line 8h from line 8c)	8i			4	(213,487)		
1	Transfers to (from) the plan (see instructions)	Ri						

	Form 5500-SF (2009)	<u> </u>	Page 2-							
Parl	IV Plan Characteristics									
9a	the plan provides pension benefits, enter the applicable pension feature	re codes from the List	of Plan Characterist	ic Cod	des in	the in:	structions:			
	2E 3D the plan provides welfare benefits, enter the applicable welfare feature									
Par	V Compliance Questions									
10	During the plan year:			T	Yes	No		Amount		
	Was there a failure to transmit to the plan any participant contribution	within the time period	described in			x				
b	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciar Were there any nonexempt transactions with any party-in-interest? (D on line 10a.)	o not include transact) ions reported	10a		x				
				105		""				
d	Was the plan covered by a fidelity bond?			10c	х				50,000	
u	or dishonesty?			10d		х				
е	Were any fees or commisions paid to any brokers, agents, or other pe insurance services or other organization that provides some or all of tr	ne benefits under the	plan? (See	100		x		,		
f	instructions.)			10e		x			····	
			•							
g h	Did the plan have any participant loans? (If "Yes," enter amount as of If this is an individual account plan, was there a blackout period? (See		3	10g		X	AND ADDRESS OF THE STATE OF THE	A 11 processor, recombining the 2 to 1 to	and the second s	
	2520.101-3.)			10h				A CONTROL OF THE PROPERTY OF T	A Company of the Comp	
i	If 10h was answered "Yes," check the box if you either provided the re exceptions to providing the notice applied under 29 CFR 2520.101-3	quired notice or one o	of the	10i				A A Property of the Control of the C		
	VI Pension Funding Compliance									
11	Is this a defined benefit plan subject to minimum funding requirements 5500))	s? (If "Yes," see instru	ctions and complete	Sche	dule S	SB (Fo	rm	Tyes	ΧNο	
12	Is this a defined contribution plan subject to the minimum funding requ								X No	
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable	2 .)							<u></u>	
a If y	If a waiver of the minimum funding standard for a prior year is being an granting the waiver		Mont	, and e	enter	the dat Day	te of the lett	er ruling Year		
b	Enter the minimum required contribution for this plan year	**	-		. Г	12b				
С	Enter the amount contributed by the employer to the plan for this plan					12c				
d	Subtract the amount in line 12c from the amount in line 12b. Enter the negative amount)	result (enter a minus	sign to the left of a			12d			0	
	Will the minimum funding amount reported on line 12d be met by the f	unding 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 ye				,			X Yes	□No	
	If "Yes," enter the amount of any plan assets that reverted to the emplo	-				13a			0	
С	Were all the plan assets distributed to participants or beneficiaries, transfer the PBGC? If during this plan year, any assets or liabilities were transferred from the which assets or liabilities were transferred. (See instructions.)							. X Yes	□No	
1	3c(1) Name of plan(s):				13	c(2) El	IN(s)	13c(3)	PN(s)	
F	PENSACOLA ENDODONTICS, LLC				20-2485950			00	001	
Cautio	n: A penalty for the late or incomplete filing of this return/report	will be assessed un	less reasonable ca	use is	esta	blish	ed.			
Under SB or	penalties of perjury and other penalties set forth in the instructions, I de Schedule MB completed and signed by an enrolled actuary, as well as the tis true, correct, and complete.	clare that I have exam	rined this return/repo	rt. inc	ludino	a. if ap	olicable, a S	chedule ge and		
SIG		10/15/10	THOMAS M. LY	ONS,	DMI	ם				
HER	Signature of plan administrator	Date	Enter name of indiv	/idual	signir	ng as p	lan adminis	trator		
SIGI		10/15/10	THOMAS M. LY							
HER	Signature of employer/plan sponsor	Date	Enter name of indiv	/idual :	signin	ıg as e	mployer or p	plan sponso	or	