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.**

OMB Nos. 1210-0110
1210-0089

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A This return/report is for: [X] single-employer plan [ ] multiple-employer plan (not multiemployer) [ ] one-participant plan

B This return/report is for: [ ] first return/report [ ] final return/report
[ ] an amended return/report [ ] short plan year return/report (less than 12 months)

C Check box if filing under: [ ] Form 5558 [ ] automatic extension [ ] DFVC program
[ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
ORTHO MOLECULAR PRODUCTS INC 401K PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/2000

2a Plan sponsor's name and address (employer, if for single-employer plan)
ORTHO MOLECULAR PRODUCTS INC

3017 BUSINESS PARK DR
STEVENS POINT, WI 54481

2b Employer Identification Number (EIN) 39-1558890

2c Plan sponsor's telephone number 815-206-6537

2d Business code (see instructions) 325410

3a Plan administrator's name and address (if same as Plan sponsor, enter "Same")
ORTHO MOLECULAR PRODUCTS INC 3017 BUSINESS PARK DR
STEVENS POINT, WI 54481

3b Administrator's EIN 39-1558890

3c Administrator's telephone number 815-206-6537

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**	120
b Total number of participants at the end of the plan year	**5b**	105
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**	114

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] 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.) [X] Yes [ ] 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**	2149321	2794191
b Total plan liabilities	**7b**	0	0
c Net plan assets (subtract line 7b from line 7a)	**7c**	2149321	2794191

8 Income, Expenses, and Transfers for this Plan Year		**(a) Amount**	**(b) Total**
a Contributions received or receivable from: **(1)** Employers	**8a(1)**	80027	
(2) Participants	**8a(2)**	361523	
(3) Others (including rollovers)	**8a(3)**	0	
b Other income (loss)	**8b**	272620	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	**8c**		714170
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	**8d**	66875	
e Certain deemed and/or corrective distributions (see instructions)	**8e**	0	
f Administrative service providers (salaries, fees, commissions)	**8f**	0	
g Other expenses	**8g**	2425	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	**8h**		69300
i Net income (loss) (subtract line 8h from line 8c)	**8i**		644870
j Transfers to (from) the plan (see instructions)	**8j**	0	

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 2F 2G 2J 2K 2T 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)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		250000
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	
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.)	10e	X		1208
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.)	10g	X		3116
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		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	10i			

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.	07/19/2011	KRISSY HEINS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

e-file Signature and Filing Authorization for the Form 5500 Series Report

Policy Number: 87-49349-71 **EIN / PN:** 391558890 **Plan Year Ending:** 12/31/10

Name of Plan: Ortho Molecular Products, Inc. 401(k) Plan

Part I - Authorization of Practitioner to Electronically Sign and File

I hereby authorize Sentry Life Insurance Company to electronically sign and file the return/report for the above-named Plan through EFAST2.

I understand that in granting this authority that:

- I must sign this Filing Authorization Form and return to Sentry;
- I must manually sign and date page 2 of the Form 5500-SF (or page 1 of the Form 5500 for large filers) and return a copy to Sentry before the electronic filing can be initiated;
- Sentry will notify the individual(s) signing below as plan administrator/plan sponsor about any inquiries and information received from EFAST2, Department of Labor (DOL) or Internal Revenue Service (IRS) regarding this annual return/report;
- A copy of my signature, as it appears on page 2 of the form 5500-SF (or page 1 of the Form 5500, if applicable), will be included with the annual return/report posted by the DOL on the Internet for public disclosure.
- Sentry shall not be deemed an administrator or other fiduciary with respect to the above named Plan solely on account of the services performed under this authorization.

This authorization is applicable only to the filing for the above-named Plan and applies only for Plan year end stated above.

Plan Administrator: _____ Date: 7-13-11

Employer/Plan Sponsor (if not the Plan Administrator): _____ Date: _____

Part II - Acknowledgement of Receipt of Authorization

On behalf of Sentry Life Insurance Company, I hereby certify that the firm will use the authority granted only for the express purposes described above; that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST2 filing; and that Sentry will take reasonable steps to assure that confidential information provided by the Plan Administrator or Plan Sponsor is protected from unauthorized disclosure.

Mark R. Hackl
President - Sentry Life Insurance Company

Please keep a signed copy for your records and remit a signed copy along with the signed copy along with the signed Form 5500-SF (or Form 5500 for large filers) back to Sentry. Sentry cannot submit the Form 5500-SF (or Form 5500, if applicable) on your behalf unless both are received in good order. The signed copies may be faxed to our attention at (715) 346-6245 or sent to us in the enclosed postage paid envelope.

Do not submit this form to the DOL unless requested to do so.

BITSDOC

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Form 5500-SF

Department of the Treasury
Internal Revenue Service

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Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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OMB Nos. 121
1210

2010

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ORTHO MOLECULAR PRODUCTS INC

3017 BUSINESS PARK DR

STEVENS POINT WI 54481

2b Employer Identification Number (EIN) 39-1558890

2c Plan sponsor's telephone number (815) 206-6537

2d Business code (see instructions) 325410

3a Plan administrator's name and address (if same as Plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

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5a Total number of participants at the beginning of the plan year	5a	120
b Total number of participants at the end of the plan year	5b	105
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	114

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] 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.) [X] Yes [ ] 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	2,149,321	2,794,191
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	2,149,321	2,794,191

8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from: (1) Employers	8a(1)	80,027	
(2) Participants	8a(2)	361,523	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	272,620	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		714,170
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	66,875	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	2,425	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		69,300
i Net income (loss) (subtract line 8h from line 8c)	8i		644,870
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristics

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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)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		250,000
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	
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.)	10e	X		1,208
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.)	10g	X		3,116
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
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SIGN HERE	[signature]	7-13-11	
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor