

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
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Part I	Annual Report Identification Information
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>12/31/2010</u>	
A This return/report is for:	☒ 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 <u>GRANDVIEW DENTAL CARE, INC. CASH BALANCE PENSION PLAN</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">1b Three-digit plan number (PN) ►</td> <td style="width:40%; text-align: center;"><u>002</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2010</u></td> </tr> </table>	1b Three-digit plan number (PN) ►	<u>002</u>	1c Effective date of plan <u>01/01/2010</u>	
1b Three-digit plan number (PN) ►	<u>002</u>				
1c Effective date of plan <u>01/01/2010</u>					
2a Plan sponsor's name and address (employer, if for single-employer plan) <u>GRANDVIEW DENTAL CARE, INC.</u> <u>1220 GRANDVIEW AVENUE</u> <u>COLUMBUS, OH 43212</u>	2b Employer Identification Number (EIN) <u>14-1871612</u>				
	2c Plan sponsor's telephone number <u>614-486-7141</u>				
	2d Business code (see instructions) <u>621210</u>				
3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") <u>GRANDVIEW DENTAL CARE, INC.</u> <u>1220 GRANDVIEW AVENUE</u> <u>COLUMBUS, OH 43212</u>	3b Administrator's EIN <u>14-1871612</u>				
	3c Administrator's telephone number <u>614-486-7141</u>				
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 <u>11</u>				
b Total number of participants at the end of the plan year	5b <u>12</u>				
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				
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	☒ 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.).....	☒ 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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th style="width:20%; text-align: center;">(a) Beginning of Year</th> <th style="width:20%; text-align: center;">(b) End of Year</th> </tr> <tr> <td>a Total plan assets</td> <td style="text-align: center;"><u>7a</u> <u>0</u></td> <td style="text-align: center;"><u>80610</u></td> </tr> <tr> <td>b Total plan liabilities</td> <td style="text-align: center;"><u>7b</u> <u>0</u></td> <td style="text-align: center;"><u>0</u></td> </tr> <tr> <td>c Net plan assets (subtract line 7b from line 7a).....</td> <td style="text-align: center;"><u>7c</u> <u>0</u></td> <td style="text-align: center;"><u>80610</u></td> </tr> </table>		(a) Beginning of Year	(b) End of Year	a Total plan assets	<u>7a</u> <u>0</u>	<u>80610</u>	b Total plan liabilities	<u>7b</u> <u>0</u>	<u>0</u>	c Net plan assets (subtract line 7b from line 7a).....	<u>7c</u> <u>0</u>	<u>80610</u>																														
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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:

1C

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**

	Yes	No	Amount
10 During the plan year:			
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		9000
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	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
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			

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.	10/03/2011	WILLIAM E. THOMPSON
	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

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>GRANDVIEW DENTAL CARE, INC. CASH BALANCE PENSION PLAN</u>	B Three-digit plan number (PN) ▶ <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>GRANDVIEW DENTAL CARE, INC.</u>	D Employer Identification Number (EIN) <u>14-1871612</u>
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500

Part I	Basic Information
1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2010</u>
2	Assets:
a	Market value 2a <u>0</u>
b	Actuarial value 2b <u>0</u>
3	Funding target/participant count breakdown
	(1) Number of participants (2) Funding Target
a	For retired participants and beneficiaries receiving payment 3a <u>0</u> <u>0</u>
b	For terminated vested participants 3b <u>0</u> <u>0</u>
c	For active participants:
(1)	Non-vested benefits 3c(1) <u>0</u>
(2)	Vested benefits 3c(2) <u>0</u>
(3)	Total active 3c(3) <u>12</u> <u>0</u>
d	Total 3d <u>12</u> <u>0</u>
4	If the plan is at-risk, check the box and complete items (a) and (b) ☐
a	Funding target disregarding prescribed at-risk assumptions 4a
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor 4b
5	Effective interest rate 5 <u>6.08</u> %
6	Target normal cost 6 <u>71783</u>

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	<u>09/15/2011</u>
Signature of actuary	Date
<u>SCOTT R. MCHENRY</u>	<u>11-06614</u>
Type or print name of actuary	Most recent enrollment number
<u>MCHENRY ADVISERS, INC.</u>	<u>800-805-9538</u>
Firm name	Telephone number (including area code)
<u>25 PICKETT PLACE</u> <u>NEW ALBANY, OH 43054</u>	
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2010
v.092308.1

Part II	Beginning of year carryover and prefunding balances	(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	0	0
9	Amount remaining (Item 7 minus item 8).....	0	0
10	Interest on item 9 using prior year's actual return of <u>0.00</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year)		0
b	Interest on (a) using prior year's effective rate of <u>0.00</u> %		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance.....		0
12	Reduction in balances due to elections or deemed elections.....	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12).....	0	0

Part III	Funding percentages		
14	Funding target attainment percentage.....	14	100.00 %
15	Adjusted funding target attainment percentage.....	15	111.04 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	100.00 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

Part IV	Contributions and liquidity shortfalls				
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
12/31/2010	39000	0	07/11/2011	5125	0
01/31/2011	5125	0	08/04/2011	5125	0
03/01/2011	5125	0	08/15/2011	4735	0
04/04/2011	5125	0			
05/04/2011	5125	0			
05/16/2011	6125	0			
Totals ▶			18(b)	80610	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contribution from prior years.....	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c	79713

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No

c If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:				
a Segment rates:	1st segment: 3.14 %	2nd segment: 5.90 %	3rd segment: 6.45 %	☐ N/A, full yield curve used
b Applicable month (enter code)	21b			0
22 Weighted average retirement age	22			65
23 Mortality table(s) (see instructions) ☒ Prescribed - combined ☐ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29)	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions).....	31	71783
32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment	0	0
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33	
34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33).....	34	71783
	Carryover balance	Prefunding balance
35 Balances used to offset funding requirement	0	0
36 Additional cash requirement (item 34 minus item 35).....	36	71783
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c).....	37	79713
38 Interest-adjusted excess contributions for current year (see instructions).....	38	7930
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37).....	39	0
40 Unpaid minimum required contribution for all years	40	0

GRANDVIEW DENTAL CARE, INC.**CASH BALANCE PENSION PLAN**

Schedule of Active Participant Data

Plan Year: 1/1/2010 to 12/31/2010

Valuation Date: 12/31/2010

Age/ Svc	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Total
0	0	0	0	0	0	0	1	0	0	0	0	1
1-4	0	4	1	2	3	0	0	0	1	0	0	11
5-9	0	0	0	0	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0	0	0	0	0
15-19	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0	0	0
30-34	0	0	0	0	0	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0	0	0	0	0	0
40+	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	4	1	2	3	0	1	0	1	0	0	12

*Employees who have not met the minimum eligibility requirements are excluded

Average Age: 37.9

Average Service: 0

GRANDVIEW DENTAL CARE, INC.**CASH BALANCE PENSION PLAN**

Statement of Actuarial Assumptions and Method

Plan Year: 1/1/2010 to 12/31/2010

Valuation Date: 12/31/2010

	<u>For PPA Funding</u>	<u>For 417(e)</u>	<u>For Actuarial Equiv.</u>
Interest Rates	Segment 1 3.14%	Pre-Retirement 5.00%	Pre-Retirement 5.00%
	Segment 2 5.90%	Post-Retirement 5.50%	Post-Retirement 5.50%
	Segment 3 6.45%		
Pre-Retirement			
Turnover	None	None	None
Mortality	None	None	None
Assumed Ret Age	Normal retirement age 65		Normal retirement age 65
Post-Retirement			
Mortality	Male-modified RP2000 combined healthy male projected 25 & 17 yrs Female-modified RP2000 combined healthy female projected 25 & 17 yrs	GAR 94 without loads projected to 2002 with scale AA 50%M/50%F	GAR 94 without loads projected to 2002 with scale AA 50%M/50%F
Assumed Benefit Form For Funding		Normal Form	
Calculated Effective Interest Rate		6.08%	

An actuarial value of assets is used for funding purposes. This year the actuarial value of assets is 100.0% of the market value of assets.

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

▶ **Round off amounts to nearest dollar.**
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A Name of plan Grandview Dental Care, Inc. Cash Balance Pension Plan	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Grandview Dental Care, Inc.	D Employer Identification Number (EIN) 14-1871612	
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B		
F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500		

Part I Basic Information			
1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2010</u>			
2 Assets:			
a Market value.....	2a		0
b Actuarial value.....	2b		0
3 Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment.....	3a	0	0
b For terminated vested participants.....	3b	0	0
c For active participants:			
(1) Non-vested benefits.....	3c(1)		0
(2) Vested benefits.....	3c(2)		0
(3) Total active.....	3c(3)	12	0
d Total.....	3d	12	0
4 If the plan is at-risk, check the box and complete items (a) and (b) ☐			
a Funding target disregarding prescribed at-risk assumptions.....	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor.....	4b		
5 Effective interest rate.....	5		6.08%
6 Target normal cost.....	6		71783

Statement by Enrolled Actuary
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		<u>9/15/11</u>
	Signature of actuary	Date
SCOTT R. MCHENRY		1106614
Type or print name of actuary		Most recent enrollment number
MCHENRY ADVISERS, INC.		800-805-9538
Firm name		Telephone number (including area code)
25 PICKETT PLACE		
NEW ALBANY OH 43054		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment 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: ☒ 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 Grandview Dental Care, Inc. Cash Balance Pension Plan	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan 01/01/2010
2a Plan sponsor's name and address (employer, if for single-employer plan) Grandview Dental Care, Inc. 1220 Grandview Avenue Columbus OH 43212	2b Employer Identification Number (EIN) 14-1871612
	2c Plan sponsor's telephone number 614-486-7141
	2d Business code (see instructions) 621210
3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") Grandview Dental Care, Inc. 1220 Grandview Avenue Columbus OH 43212	3b Administrator's EIN 14-1871612
	3c Administrator's telephone number 614-486-7141
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 11
b Total number of participants at the end of the plan year	5b 12
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
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	☒ 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.)	☒ 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 0	80610
b Total plan liabilities	7b 0	0
c Net plan assets (subtract line 7b from line 7a)	7c 0	80610
8 Income, Expenses, and Transfers for this Plan Year	(a) Amount	(b) Total
a Contributions received or receivable from:		
(1) Employers	8a(1) 80610	
(2) Participants	8a(2) 0	
(3) Others (including rollovers)	8a(3) 0	
b Other income (loss)	8b 0	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	80610
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d 0	
e Certain deemed and/or corrective distributions (see instructions)	8e 0	
f Administrative service providers (salaries, fees, commissions)	8f 0	
g Other expenses	8g 0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	0
i Net income (loss) (subtract line 8h from line 8c)	8i	80610
j Transfers to (from) the plan (see instructions)	8j 0	

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

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:

1C

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**

	Yes	No	Amount
10 During the plan year:			
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	9000
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	
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	
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 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** _____

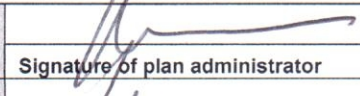
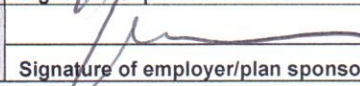
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

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		9-29-11	William E. Thompson
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		9-29-11	William E. Thompson
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

GRANDVIEW DENTAL CARE, INC.
CASH BALANCE PENSION PLAN

Summary of Plan Provisions
Plan Year: 1/1/2010 to 12/31/2010

Plan Effective Date	January 1, 2010
Plan Year	From January 1 to December 31
Eligibility	<p>All employees not excluded by class are eligible to enter on the January 1 or July 1 coincident with or following the completion of the following requirements:</p> <p>1 year of service Minimum age 21</p>
Normal Retirement Age	All participants are eligible to retire with their full retirement benefit on attainment of age 65.
Normal Retirement Benefit	<p>Based on their group classification, participants receive a cash balance contribution equal to a percentage of compensation as follows:</p> <p>Benefit Provided by Cash Balance Allocations of: \$70,000 for William E. Thompson, and 2.50% of compensation for all other participants.</p> <p>Maximum benefit is \$16,250 per month Maximum percent of salary is 100%</p>
Normal Form of Benefit	A benefit payable for the life of the participant
Accrued Benefit	<p>A fraction of the normal retirement benefit calculated based on the assumption that the average salary preceding termination equals the average salary at retirement such fraction being equal to the years to date divided by what the years at retirement would have been had employment continued until retirement</p> <p>Credited years are plan years commencing with the year of entry and ending with the retirement year excluding the following:</p> <p>Years with less than 1,000 hours</p>
Termination Benefit	<p>Upon termination for any reason other than death, disability or retirement a participant shall be entitled to a portion of the actuarial equivalent of his accrued benefit in accordance with the following vesting schedule:</p>

Credited Years	Vested Percent
1	0

GRANDVIEW DENTAL CARE, INC.
CASH BALANCE PENSION PLAN

Summary of Plan Provisions
Plan Year: 1/1/2010 to 12/31/2010

Credited Years	Vested Percent
2	0
3	100

Credited years are plan years commencing with the year of hire and ending with the retirement year excluding the following:

Years before age 18
Years with less than 1,000 hours

Top-Heavy Minimum Benefit

Top-heavy minimum benefits are provided under another plan of the employer.

Top-Heavy Status

A plan is top-heavy if over 60% of the value of all accrued benefits in all of the employer's plans are for the benefit of key employees. A key employee is generally an officer or owner of the company. This plan is currently top-heavy.

Death Benefit

Actuarial Equivalent of the accrued benefit earned to date of death

GRANDVIEW DENTAL CARE, INC.
CASH BALANCE PENSION PLAN
Employer ID# 14-1871612: Plan No. 002

Schedule SB, line 19 - Discounted Employer Contributions

Valuation Date: December 31, 2010

<u>Date</u>	<u>Amount</u>	<u>Year</u>	<u>Rate</u>	<u>Adj Ctb</u>
12-31-2010	39,000.00	2010	6.08%	39,000.00
01-31-2011	5,125.00	2010	6.08%	5,099.85
03-01-2011	5,125.00	2010	6.08%	5,074.03
04-04-2011	5,125.00	2010	6.08%	5,046.73
05-04-2011	5,125.00	2010	6.08%	5,021.97
05-16-2011	6,125.00	2010	6.08%	5,990.44
07-11-2011	5,125.00	2010	6.08%	4,967.29
08-04-2011	5,125.00	2010	6.08%	4,948.41
08-15-2011	4,735.00	2010	6.08%	4,563.87
Totals:	80,610.00			79,712.58

19	Discounted employer contributions -- see instructions for small plan with a valuation date after the beginning of the year			
a	Contributions allocated toward unpaid minimum required contribution from prior years	19a		0.00
b	Contributions made to avoid benefit restrictions adjusted to valuation date	19b		0.00
c	Contributions allocated toward minimum required contribution for current year, adjusted to valuation date	19c		79,712.58

Schedule SB, line 22 – Description of Weighted Average Retirement Age

Plan: Grandview Dental Care, Inc. Cash Balance Pension Plan

Sponsor: Grandview Dental Care, Inc.

EIN: 14-1871612

Plan Number: 002

Plan Year: 01/01/2010 – 12/31/2010

Line 22

The Weighted Average Retirement Age is calculated based upon the PPA
Funding Target:

Retirement Age	PPA Funding Target
65	71,783