Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

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:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [X] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
CERAPEDICS IN 401(K) PROFIT SHARING PLAN AND TRUST

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/2007

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
CERAPEDICS INC

BRITT PEARSON

11025 DOVER STREET
SUITE 1600
WESTMINSTER, CO 80021

11025 DOVER STREET
SUITE 1600
WESTMINSTER, CO 80021

2b Employer Identification Number (EIN)
20-8302692

2c Sponsor's telephone number
303-974-6275

2d Business code (see instructions)
541700

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 accompanying schedules, statements and attachments, 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.	03/21/2012	BRITT PEARSON
	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
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

CERAPEDICS INC
BRITT PEARSON
11025 DOVER STREET
SUITE 1600
WESTMINSTER, CO 80021

3b Administrator's EIN: 20-8302692

3c Administrator's telephone number: 303-974-6275

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:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	15
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	0
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	0
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	0
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a 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 3E

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

9a Plan funding arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)	X	**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)		**H** (Financial Information)
(2)	X	**I** (Financial Information – Small Plan)
(3)		**A** (Insurance Information)
(4)		**C** (Service Provider Information)
(5)		**D** (DFE/Participating Plan Information)
(6)		**G** (Financial Transaction Schedules)

SCHEDULE I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
CERAPEDICS IN 401(K) PROFIT SHARING PLAN AND TRUST

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CERAPEDICS INC

D Employer Identification Number (EIN)
20-8302692

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

			(a) Beginning of Year	**(b)** End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	**1a**	97913	0
b	Total plan liabilities	**1b**	0	0
c	Net plan assets (subtract line 1b from line 1a)	**1c**	97913	0
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable:			
	(1) Employers	**2a(1)**	0	
	(2) Participants	**2a(2)**	0	
	(3) Others (including rollovers)	**2a(3)**	0	
b	Noncash contributions	**2b**	0	
c	Other income	**2c**	0	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		0
e	Benefits paid (including direct rollovers)	**2e**	0	
f	Corrective distributions (see instructions)	**2f**	0	
g	Certain deemed distributions of participant loans (see instructions)	**2g**	0	
h	Administrative service providers (salaries, fees, and commissions)	**2h**	0	
i	Other expenses	**2i**	0	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	**2j**		0
k	Net income (loss) (subtract line 2j from line 2d)	**2k**		0
l	Transfers to (from) the plan (see instructions)	**2l**		-97913

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	**3a**			
b	Employer real property	**3b**			
c	Real estate (other than employer real property)	**3c**			
d	Employer securities	**3d**			
e	Participant loans	**3e**			

			Yes	No	Amount
3f	Loans (other than to participants)	3f			
g	Tangible personal property	3g			

Part II Compliance Questions

4 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? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		20000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j	X		
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year..... [X] **Yes** [ ] **No** **Amount:** 0

5b 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.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)
ADP TOTALSOUCE RETIREMENT SAVINGS PLAN	59-3216484	001

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
CERAPEDICS IN 401(K) PROFIT SHARING PLAN AND TRUST

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CERAPEDICS INC

D Employer Identification Number (EIN)
20-8302692

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): _____ _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year. **3**

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section of 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ **Yes** ☐ **No** ☒ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 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 ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year **6a** 0

b Enter the amount contributed by the employer to the plan for this plan year **6b** 0

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c** 0

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☒ **N/A**

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ **Yes** ☐ **No** ☒ **N/A**

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box. ..... ☐ **Increase** ☐ **Decrease** ☐ **Both** ☒ **No**

Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☐ **No**

11 **a** Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☐ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☐ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☐ **No**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

14 Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	**14a**	15
b The plan year immediately preceding the current plan year	**14b**	13
c The second preceding plan year	**14c**	7

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	0.00
b The corresponding number for the second preceding plan year	**15b**	0.00

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	**16a**	0
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

19 If the total number of participants is 1,000 or more, complete items (a) through (c)

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate item 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

CERAPEDICS
Enhancing the Science of Bone Repair

March 21, 2012

Internal Revenue Service
Ogden UT 84201-0018

RE:		
	Notice:	CP-406
	Taxpayer Identification Number:	20-8302692
	Form:	5500
	Plan #:	001
	Plan Year Ending:	12-31-2009

To whom it may concern,

Cerapedics Inc. joined ADP Total Source, a PEO organization late in 2008. As part of this process, the Cerapedics Inc 401 (K) Profit Sharing Plan & Trust was merged into the ADP TotalSource Group plan. At the time, Cerapedics utilized the services of Paychex Retirement Services for the 401K Plan. All documents were completed regarding the merger of the plans and on December 12, 2008, Cerapedics instructed Paychex Retirement Services to merge the plans as well as authorized the filing of the Final Form 5500. It was not until I received the "Final Notice – Your Annual Form 500 is overdue" did I know that this was not yet done. Furthermore, this final notice was the only notice Cerapedics received. I followed-up with Paychex and they indicated that they did not and would not file the Final Form. Furthermore, they would not disclose whether they had received prior IRS notices but they did indicate that they were the plan administrator of record. I do not know what they meant by that.

In order to become compliant, we are filing the Final Report Form 5500 for the plan. In addition to the Form 5500, Schedule I, and Schedule R, I am also enclosing:

- The December 12, 2008 fax transmission to Paychex Retirement Services
- The Complete letter faxed on December 12, 2008 with the letter written on December 11, 2008
- A Google printout showing that the fax confirmation page phone number is a Paychex phone number

Regards,

Britt V. Pearson
Vice President of Finance

Cerapedics, Inc.
11025 Dover St., Suite 1600
Westminster, Colorado 80021
303.974.6275 *office*
303.974.6285 *fax*

cerapedics.com

****
*** FAX TX REPORT ***
****

TRANSMISSION OK

JOB NO.	1745
DESTINATION ADDRESS	9p13033078640
PSWD/SUBADDRESS	
DESTINATION ID	
ST. TIME	12/12 08:29
USAGE T	01'34
PGS.	2
RESULT	OK

CERAPEDICS
Enhancing the Science of Bone Repair

December 11, 2008

Paychex Retirement Services
1175 John Street
West Henrietta, NY 14586

RE: Cerapedics, Inc. 401K Plan - Account No. 0065-7762

Dear Paychex:

This is to notify you that we have elected to **merge** our existing retirement plan into the ADP TotalSource Retirement Savings Plan. The ADP TotalSource Retirement Savings Plan is a Multiple Employer Plan and as such, a plan merger with specific considerations is required such as **short plan year testing for our existing retirement plan and after the transfer, final 5500 reporting requirements,** which will be prepared by **Paychex** after the transfer of assets to the Plan. Schedule I section 5b of the Final Form 5500 should reflect the following information:

5b (1) ADP TotalSource Retirement Savings Plan
5b (2) 59-3216484
5b (3) 001

I authorize **Paychex** to conduct short plan year testing and preparation of the final Form 5500 for this merger.

CERAPEDICS
Enhancing the Science of Bone Repair

December 11, 2008

Paychex Retirement Services
1175 John Street
West Henrietta, NY 14586

RE: Cerapedics, Inc. 401K Plan - Account No. 0065-7762

Dear Paychex:

This is to notify you that we have elected to **merge** our existing retirement plan into the ADP TotalSource Retirement Savings Plan. The ADP TotalSource Retirement Savings Plan is a Multiple Employer Plan and as such, a plan merger with specific considerations is required such as **short plan year testing for our existing retirement plan and after the transfer, final 5500 reporting requirements,** which will be prepared by **Paychex** after the transfer of assets to the Plan. Schedule I section 5b of the Final Form 5500 should reflect the following information:

5b (1) ADP TotalSource Retirement Savings Plan
5b (2) 59-3216484
5b (3) 001

I authorize **Paychex** to conduct short plan year testing and preparation of the final Form 5500 for this merger.

Cerapedics, Inc.
11025 Dover St., Suite 1600
Westminster, Colorado 80021
303.974.6275 *office*
303.974.6285 *fax*

cerapedics.com

A MassMutual Retirement Services Representative will contact you shortly to discuss the process and how it should be handled to ensure a successful plan merger. In the interim, you are hereby authorized to release to MassMutual all documents, data, and information pertaining to our plan with you, including but not limited to the following:

DOCUMENTS:

- ☐ IRS Determination Letter **OR** Plan Document
- ☐ Executed copy of the Adoption Agreement

LOANS

- ☐ Loan Amortization Schedules
- ☐ Last Payment Date applied to Loan
- ☐ Outstanding Loan Balances as of Last Payroll Data, noted below under LAST PAYROLL
- ☐ Highest outstanding loan balances in past 12 months

VALUATION:

- ☐ Copy of most recent plan valuation by participant / fund / source
- ☐ Participant hardship balances (12/31/88 net balances/post 12/31/88 net contributions)
- ☐ Participant after-tax balances (pre-87 contributions & post-86 net contributions)
- ☐ List of investment funds offered in the plan for mapping purposes
- ☐ Copy of compliance testing:
  - ☐ ACP/ADP & Top Heavy

TAX FILINGS:

- ☐ Copy of most recent Form 5500

LAST PAYROLL

☐ Please note, the last payroll to be deposited to the plan prior to the merger will be 12/31/08.

Please send documentation to: MassMutual
Attention: Kim Daley Lamirande / Bonnie Mikalson
1295 State Street N405
Springfield, MA 01111
rscsoadptotalsource@massmutual.com

Thank you in advance for your assistance in the merger of these plans.

Sincerely,

Britt V. Pearson
Director of Finance

cerapedics.com

Search

About 543 results (0.23 seconds)

Everything
Images
Maps
Videos
News
Shopping
More

Denver, CO
Change location

All results
Sites with images
Related searches
More search tools

Paychex Inc in Denver, CO - (303) 307-0505
www.whitepages.com/business/paychex-inc-denver-co
Tweet. 4400 Kittredge St Ste 50. Denver, CO 80239. Neighborhood: Gateway. (303) 307-0505 (888) 814-6754 Fax **(303) 307-8640**. View Website » ...

Paychex in Denver, CO - (303) 307-0505
usps2.whitepages.com/business/paychex-denver-co
Tweet. 4400 Kittredge St. Denver, CO 80239. Neighborhood: Gateway. (303) 307 - 0505 Fax **(303) 307-8640**. Related Categories. Accounting & Bookkeeping ...

Office Locations | Paychex Corporate
www.paychex.com/company/locations.aspx
DENVER - Branch. 4400 Kittredge St. Suite 50. Denver, CO 80239. P: (303) 307-0505. F: **(303) 307-8640**. Back to top. Connecticut. HARTFORD - Branch ...

303-307 / (303) 307 Phone Number Results
mrnumber.com/1-303-307
... 303-307-0503; 303-307-4860; 303-307-5562; 303-307-9467; 303-307-5415; 303-307-2778; 303-307-5608; 303-307-8754; **303-307-8640**; 303-307-7832 ...

Paychex, Inc. - Brookfield, US-WI, 262-782-8123
free.salesfuel.com/companies/Paychex-Inc--2375224.html
375 Bishops Way STE 190. Brookfield WI 53005-6200. US, p. 262-782-8123 f. **303-307-8640** http://www.paychex.com · View More Information ...

Certified in Colorado - 9
www.trivok.com/colorado/certified_9.htm
10+ items – List of companies that provide Certified services and products in ...
Banner Occupational Health Services Location: Greeley (Colorado) - 1801 ...
Paychex Inc Location: Denver (Colorado) - 4400 ...

(303)307-8002 to 303-307-9998 DENVER CO Lataitude
www.cellownerlookup.com/1/.../303307xxxx-name-and-address.php
... 303-307-8632 303-307-8633 303-307-8634 303-307-8635 303-307-8636 303 -307-8637 303-307-8638 303-307-8639 **303-307-8640** 303-307-8641 ...

303-307-0000 Denver, CO: Find out who is calling you?
www.lookupmonkey.com/Colorado/303-307
303-307-5948, 303-307-2852, 303-307-5561, 303-307-4904, 303-307-8526, 303-307-9155, 303-307-7702, 303-307-7451, 303-307-7869, **303-307-8640** ...

303-307 Free Denver Reverse Lookup
www.reversenum.com/303-307.php
... 303-307-7535 | 303-307-8570 | 303-307-5096 | 303-307-9720 | 303-307-7066 | 303-307-9060 | 303-307-3285 | **303-307-8640** | 303-307-5014 ...

Reverse Lookup (303)-307 Denver Area Phone Numbers
reversenumberdatabase.com › Area Code 303
... 303-307-9399 | 303-307-5491 | 303-307-5786 | 303-307-9506 | 303-307-8031 | 303-307-7158 | 303-307-0134 | **303-307-8640** | 303-307-5118 ...