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| 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), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | OMB Nos. 1210-0110 1210-0089 2012 This Form is Open to Public Inspection |
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| Part I | Annual Report Identification Information |
| For calendar plan year 2012 or fiscal plan year beginning <u>01/01/2012</u> and ending <u>12/31/2012</u> | |
| A This return/report is for: | <input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____ |
| B This return/report is: | <input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months). |
| C If the plan is a collectively-bargained plan, check here. | <input type="checkbox"/> |
| D Check box if filing under: | <input type="checkbox"/> Form 5558; <input checked="" type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description) |

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| Part II | Basic Plan Information —enter all requested information | | |
| 1a Name of plan BOISE ORAL AND MAXILLOFACIAL SURGERY PA EMPLOYEE PROFIT SHARING PLAN | 1b Three-digit plan number (PN) ▶ <u>001</u> | 1c Effective date of plan <u>01/01/1982</u> | |
| 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) BOISE ORAL AND MAXILLOFACIAL SURGERY PA KEVIN KEMPERS 6363 W EMERALD ST #103 BOISE, ID 83704 | 2b Employer Identification Number (EIN) <u>82-0368332</u> | 2c Sponsor's telephone number <u>208-376-4550</u> | 2d Business code (see instructions) <u>621210</u> |

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.

| | | | |
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| SIGN HERE | Filed with authorized/valid electronic signature. | 09/16/2013 | KIM PECK |
| | 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 |
| Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional) | | | Preparer's telephone number (optional) |

| | | |
|---|-----------|--|
| 3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address BOISE ORAL AND MAXILLOFACIAL SURGERY PA KEVIN KEMPERS 6363 W EMERALD ST #103 BOISE, ID 83704 | | 3b Administrator's EIN 82-0368332 |
| | | 3c Administrator's telephone number 208-376-4550 |
| 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 | 9 |
| b Retired or separated participants receiving benefits..... | 6b | 3 |
| c Other retired or separated participants entitled to future benefits..... | 6c | |
| d Subtotal. Add lines 6a , 6b , and 6c | 6d | 12 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... | 6e | |
| f Total. Add lines 6d and 6e | 6f | 12 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... | 6g | 12 |
| h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6h | 1 |
| 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 Characteristics Codes in the instructions: 2A 2E 2F 2G 2J | | |
| b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: | | |
| 9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | | 9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> 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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | | b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input checked="" type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

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| SCHEDULE I (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> | 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 <div style="font-size: 24pt; font-weight: bold;">2012</div> This Form is Open to Public Inspection |
| For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012 | | |
| A Name of plan BOISE ORAL AND MAXILLOFACIAL SURGERY PA EMPLOYEE PROFIT SHARING PLAN | | B Three-digit plan number (PN) ► 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOISE ORAL AND MAXILLOFACIAL SURGERY PA | | D Employer Identification Number (EIN) 82-0368332 |

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.

| | |
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| 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 | 2172985 | 949186 |
| b Total plan liabilities | 1b | | |
| c Net plan assets (subtract line 1b from line 1a) | 1c | 2172985 | 949186 |
| 2 Income, Expenses, and Transfers for this Plan Year: | | (a) Amount | (b) Total |
| a Contributions received or receivable: | | | |
| (1) Employers | 2a(1) | 43749 | |
| (2) Participants | 2a(2) | 18650 | |
| (3) Others (including rollovers) | 2a(3) | | |
| b Noncash contributions | 2b | | |
| c Other income | 2c | 143413 | |
| d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) | 2d | | 205812 |
| e Benefits paid (including direct rollovers) | 2e | 1423926 | |
| f Corrective distributions (see instructions) | 2f | | |
| g Certain deemed distributions of participant loans (see instructions) | 2g | | |
| h Administrative service providers (salaries, fees, and commissions) | 2h | 5685 | |
| i Other expenses | 2i | | |
| j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i) | 2j | | 1429611 |
| k Net income (loss) (subtract line 2j from line 2d) | 2k | | -1223799 |
| l Transfers to (from) the plan (see instructions) | 2l | | |

| | | | | |
|--|-----------|-----|----|--------|
| 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 | | X | |
| b Employer real property | 3b | | X | |
| c Real estate (other than employer real property) | 3c | | X | |
| d Employer securities | 3d | | X | |
| e Participant loans | 3e | X | | 36926 |

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

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.)..... | | 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. | | X | |
| c | Were any leases to which the plan was a party in default or classified during the year as uncollectible? | | X | |
| d | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) | | X | |
| e | Was the plan covered by a fidelity bond? | X | | 100000 |
| f | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | 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? | | 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? | | 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?..... | | 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? | | 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.) | X | | |
| l | Has the plan failed to provide any benefit when due under the plan? | | X | |
| m | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)..... | 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 | X | | |

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..... ☐ Yes ☒ No Amount:

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) |
|------------------------------|---------------------|--------------------|
| | | |
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Part III Trust Information (optional)

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|-------------------------|-----------------------|
| 6a Name of trust | 6b Trust's EIN |
|-------------------------|-----------------------|

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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), 6057(b), 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**2012****This Form is Open to Public Inspection****Part I Annual Report Identification Information**

For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012

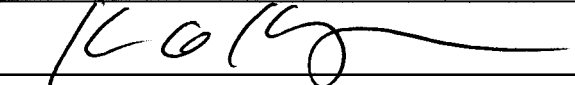
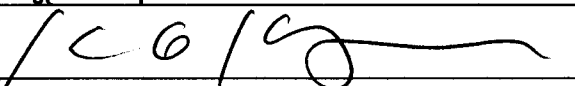
- A** This return/report is for: ☐ a multiemployer plan; ☐ a multiple-employer plan; or
☐ a single-employer plan; ☐ a DFE (specify) _____
- B** This return/report is: ☐ the first return/report; ☐ the final return/report;
☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
- 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 BOISE ORAL AND MAXILLOFACIAL SURGERY PA EMPLOYEE PROFIT SHARING PLAN | | 1b Three-digit plan number (PN) ▶ 001 |
| | | 1c Effective date of plan 01/01/1982 |
| 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) BOISE ORAL AND MAXILLOFACIAL SURGERY PA KEVIN KEMPERS 6363 W EMERALD ST #103 BOISE, ID 83704 | | 2b Employer Identification Number (EIN) 82-0368332 |
| | | 2c Sponsor's telephone number 208-376-4550 |
| | | 2d Business code (see instructions) 621210 |

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 |  | 9/9/13 | KEVIN G KEMPERS |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE |  | 9/9/13 | KEVIN G KEMPERS |
| | 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 |
| Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional) | | | Preparer's telephone number (optional) |
| | | | |

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

Form 5500 (2012)
v. 120126

| | |
|---|---|
| 3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address BOISE ORAL AND MAXILLOFACIAL SURGERY PA KEVIN KEMPERS 6363 W EMERALD ST #103 BOISE, ID 83704 | 3b Administrator's EIN 82-0368332 3c Administrator's telephone number 208-376-4550 |
| 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 |
| 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 |
| b Retired or separated participants receiving benefits..... | 6b |
| c Other retired or separated participants entitled to future benefits..... | 6c |
| d Subtotal. Add lines 6a, 6b, and 6c..... | 6d |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... | 6e |
| f Total. Add lines 6d and 6e..... | 6f |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... | 6g |
| h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6h |
| 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 Characteristics Codes in the instructions:

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

| | |
|---|---|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input type="checkbox"/> Insurance | (1) <input type="checkbox"/> Insurance |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input type="checkbox"/> Trust | (3) <input type="checkbox"/> Trust |
| (4) <input type="checkbox"/> General assets of the sponsor | (4) <input type="checkbox"/> 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) ☐ **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) ☐ **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)