

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 sections 6057(b) and 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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2013</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information			
For calendar plan year 2013 or fiscal plan year beginning <u>01/01/2013</u> and ending <u>12/31/2013</u>			
A	This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) <input type="checkbox"/> a one-participant plan	
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	Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)	

Part II Basic Plan Information —enter all requested information			
1a	Name of plan <u>RONALD E. FROST DDS PS 401(K) PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>001</u>
		1c	Effective date of plan <u>01/01/1998</u>
2a	Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>RONALD E. FROST DDS PS</u> <u>16701 CLEVELAND ST SUITE 200</u> <u>REDMOND, WA 98052</u>	2b	Employer Identification Number (EIN) <u>91-1191001</u>
		2c	Sponsor's telephone number <u>425-883-4099</u>
		2d	Business code (see instructions) <u>621210</u>
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	3b	Administrator's EIN
		3c	Administrator's telephone number
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.	4b	EIN
a	Sponsor's name	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>11</u>
c	Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c	<u>11</u>
6a	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.			
c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not determined

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.	10/04/2014	RONALD E. FROST
	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
Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)			Preparer's telephone number (optional)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	465474	561893
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	465474	561893
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	46596	
(2) Participants	8a(2)	51200	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	72270	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		170066
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	70090	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	3557	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		73647
i Net income (loss) (subtract line 8h from line 8c)	8i		96419
j Transfers to (from) the plan (see instructions)	8j		

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 2J 2K 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	150000
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	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) and line 11a below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39	11a
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ..	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(If "Yes," complete line 12a or lines 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)

Part VIII Trust Information (optional)

14a Name of trust	14b Trust's EIN

2013 Form 5500-SF e-file Signature Authorization

Ronald E. Frost DDS PS
Ronald E. Frost DDS PS 401(k) Plan 001
16701 Cleveland St Suite 200
Redmond, WA 98052

Employer Identification Number: 91-1191001

Client Identification Number: 26280


You, as plan administrator, are authorizing that Martin Boyle PLLC electronically file the 2013 Form 5500-SF for Ronald E. Frost DDS PS 401(k) Plan as an EFAST2 Service Provider.

Authorization

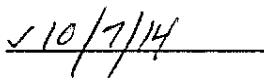
As plan administrator for Ronald E. Frost DDS PS 401(k) Plan, I authorize Martin Boyle PLLC to electronically file Form 5500-SF for the tax year 2013. I understand that a PDF copy of the first two pages of the manually signed form will be submitted to EFAST2 with the electronic file, and that the image of my signature will be included with the rest of the return / report posted by the Department of Labor on the internet for public disclosure.

Please sign and date below:

Plan Administrator Authorization

 Ronald E. Frost DDS PS

Date:

 10/7/14

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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 sections 6057(b) and 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 2013 This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2013 or fiscal plan year beginning _____ and ending _____	
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Part II Basic Plan Information—enter all requested information	
1a Name of plan Ronald E. Frost DDS PS 401(k) Plan 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) Ronald E. Frost DDS PS 16701 Cleveland St Suite 200 Redmond WA 98052 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	1b Three-digit plan number (PN) ► 001 1c Effective date of plan 01/01/1998 2b Employer Identification No. (EIN) 91-1191001 2c Sponsor's telephone number 425-883-4099 2d Business code (see instr.) 621210 3b Administrator's EIN 3c Administrator's telephone number
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 5a Total number of participants at the beginning of the plan year _____ b Total number of participants at the end of the plan year _____ c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) _____	4b EIN 4c PN 5a 11 5b 11 5c 11
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined	

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	 Signature of plan administrator	10/03/2014 Date	Ronald E. Frost 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

Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)	Preparer's telephone number (optional)
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Ronald E. Frost DDS PS

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Part III Financial Information			
7 Plan Assets and Liabilities			
a Total plan assets	7a	(a) Beginning of Year	(b) End of Year
b Total plan liabilities	7b	465474	561893
c Net plan assets (subtract line 7b from line 7a)	7c	465474	561893
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	46,596	
(2) Participants	8a(2)	51,200	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	72,270	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		170,066
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	70,090	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	3,557	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		73,647
i Net income (loss) (subtract line 8h from line 8c)	8i		96,419
j Transfers to (from) the plan (see instructions)	8j		
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 2J 2K 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
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	
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		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) and line 11a below)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39	11a		
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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		

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Ronald E. Frost DDS PS

91-1191001

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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Part VII Plan Terminations and Transfers of Assets			
13a	Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)
Part VIII Trust Information (optional)			
14a	Name of trust	14b	Trust's EIN