

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;">2014</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information		
For calendar plan year 2014 or fiscal plan year beginning <u>01/01/2014</u> and ending <u>12/31/2014</u>		
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)	
B This return/report is	<input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan <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>CAPITAL DISTRICT PEDIATRIC DENTISTRY, PC 401(K) PROFIT SHARING PLAN</u>	1b Three-digit plan number (PN) ▶	<u>002</u>
	1c Effective date of plan	<u>01/01/2002</u>
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>CAPITAL DISTRICT PEDIATRIC DENTISTRY, PC</u> <u>9 CENTURY HILL DRIVE</u> <u>LATHAM, NY 12110</u>	2b Employer Identification Number (EIN)	<u>14-1669134</u>
	2c Sponsor's telephone number	<u>518-785-3911</u>
	2d Business code (see instructions)	<u>621210</u>
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	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	4b EIN	
	4c PN	
5a Total number of participants at the beginning of the plan year	5a	<u>34</u>
b Total number of participants at the end of the plan year.....	5b	<u>37</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>24</u>
d(1) Total number of active participants at the beginning of the plan year.....	5d(1)	<u>33</u>
d(2) Total number of active participants at the end of the plan year.....	5d(2)	<u>33</u>
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	5e	<u>0</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, 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.		
	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)

- 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 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)? ☐ Yes ☐ No ☐ Not determined

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	2162946	2457150
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	2162946	2457150
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	57085	
(2) Participants	8a(2)	133408	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	160903	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		351396
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	37094	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	20098	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		57192
i Net income (loss) (subtract line 8h from line 8c)	8i		294204
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2F 2G 2J 2K 2R 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2829
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c Was the plan covered by a fidelity bond?	10c	<input checked="" type="checkbox"/>	<input type="checkbox"/>	250000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
f Has the plan failed to provide any benefit when due under the plan?	10f	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	

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) ☐ Yes ☒ 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? .. ☐ Yes ☒ 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 _____

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	

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)

14a Name of trust	14b Trust's EIN

Form 5500-SF, Line 10a**Schedule of Delinquent Participant Contributions****Plan Name: Capital District Pediatric Dentistry, PC 401(k) Profit Sharing Plan****EIN: 14-1669134****PN: 002****Plan Year End: December 31, 2014**

	Participant Contributions Transferred Late to Plan	Total that Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002-51
Year	<input type="checkbox"/> Check here if Late Participant Loan Repayments are included	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
2014	\$2,829		\$2,829		

All late participant contributions and lost earnings have been remitted to the Plan.

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B This return/report is:	<input type="checkbox"/> a one-participant plan	<input type="checkbox"/> a foreign plan	
	<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		1b Three-digit plan number (PN) ►	002
Capital District Pediatric Dentistry, PC 401(k) Profit Sharing Plan		1c Effective date of plan	01/01/2002
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) Capital District Pediatric Dentistry, PC 9 Century Hill Drive US Latham NY 12110	2b Employer Identification Number (EIN) 14-1669134		
	2c Sponsor's telephone number (518) 785-3911		
	2d Business code (see instructions) 621210		
	3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name		
		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	34	
b Total number of participants at the end of the plan year	5b	37	
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c	24	
d(1) Total number of active participants at the beginning of the plan year	5d(1)	33	
d(2) Total number of active participants at the end of the plan year	5d(2)	33	
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0	

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		9.15.15	Jason T. Decker, DDS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		9.15.15	Jason T. Decker, DDS
	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)

- 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 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)? ☐ Yes ☐ No ☐ Not determined

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	2,162,946	2,457,150
b Total plan liabilities.....	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	2,162,946	2,457,150
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	57,085	
(2) Participants	8a(2)	133,408	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	160,903	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		351,396
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	37,094	
e Certain deemed and/or corrective distributions (see instructions) ...	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	20,098	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		57,192
i Net income (loss) (subtract line 8h from line 8c)	8i		294,204
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2F 2G 2J 2K 2R 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		2,829
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		250,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
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) ☐ Yes ☒ No

11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 ☐ 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 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