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).

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

OMB Nos. 1210-0110
1210-0089

2014

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/1992

2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)
SACHEM DENTAL GROUP, LLP

469 HAWKINS AVENUE
LAKE RONKONKOMA, NY 11779

2b Employer Identification Number (EIN)
11-2547652

2c Plan Sponsor's telephone number
631-588-3674

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	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
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 [X] 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:	**4b** EIN	
a Sponsor's name	**4c** PN	

5	Total number of participants at the beginning of the plan year	**5**	123
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	94
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	117
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	27
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	144
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	144
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	107
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	2
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 2K 2T 3B 3D

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)	[X] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) .....…… ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ……..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SACHEM DENTAL GROUP, LLP

D Employer Identification Number (EIN)
11-2547652

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
04-1590850	65935	RM 82842-1	102	01/01/2014	12/31/2014

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
35455	

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MORGAN STANLEY INS SERVICES INC
34 EXCHANGE PLACE
JERSEY CITY, NJ 07311

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
35455			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	2256768
5	Current value of plan's interest under this contract in separate accounts at year end	5	4985982

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	2519946
c	Additions: (1) Contributions deposited during the year	7c(1)	666155		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	75193		
	(4) Transferred from separate account	7c(4)	81935		
	(5) Other (specify below)	7c(5)	31689		
	▶ LN INTEREST, LN PRIN, LOAN DEFAULT, TRANS ASSETS				
	(6)Total additions			7c(6)	854972
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	3374918
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	555521		
	(2) Administration charge made by carrier	7e(2)	13847		
	(3) Transferred to separate account	7e(3)	543214		
	(4) Other (specify below)	7e(4)	5568		
	▶ LN DIST				
	(5) Total deductions			7e(5)	1118150
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	2256768

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2014** **This Form is Open to Public Inspection.**

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SACHEM DENTAL GROUP, LLP

D Employer Identification Number (EIN)
11-2547652

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . [X] Yes [ ] No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

MASSACHUSETTS MUTUAL LIFE INS. CO.

04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
52 60 63 64 67 68 72	CONTRACT ADMINISTRATOR	36657	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

UNITED BENEFIT PENSIONS INC.

35 PINELAWN ROAD
MELVILLE, NY 11747

36-4517541

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	THIRD PARTY ADMINISTRATO	0	Yes [X] No [ ]	Yes [ ] No [X]	2676	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

THE BENEFIT PRACTICE

13-4144565

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	THIRD PARTY ADMINISTRATO	0	Yes [X] No [ ]	Yes [ ] No [X]	2636	Yes [ ] No [X]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

UNITED BENEFIT PENSIONS INC.

35 PINELAWN ROAD
MELVILLE, NY 11747

36-4517541

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	THIRD PARTY ADMINISTRATO	0	Yes [X] No [ ]	Yes [X] No [ ]	750	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

MORGAN STANLEY SMITH BARNEY LLC

26-4310632

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	ADVISOR	0	Yes [X] No [ ]	Yes [ ] No [X]	347	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

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(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

OMB No. 1210-0110

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
SACHEM DENTAL GROUP, LLP

D Employer Identification Number (EIN)
11-2547652

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AD (SEL GR OPPORTUNITIES)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-013	P	420677

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AE (PREMIER CORE BOND)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-014	P	318485

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AG (PREMIER MONEY MARKET)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFDE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-016	P	388020

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AH (SEL OVERSEAS)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-155	P	72583

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AK (SELECT FUNDAMENTAL VAL)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-175	P	51953

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AV (SELECT FOCUSED VALUE)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-027	P	368739

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-C2 (REAL ESTATE)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
04-1590850-272	P	32758

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-C9 (DEVELOPING MARKET)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0324299-148	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1334

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CBA (ATLANTA CAP SMID-CAP)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0779283-197	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 159673

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CBF (EQUITY DIVIDEND)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-363	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 410755

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CCV (BALANCED-RISK ALLOCATION)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0779283-219	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 909323

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-LB (SEL BLACKROCK GLOBAL)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 04-1590850-050	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 276889

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-NM (PRM OPPENHEIMER FDS SM CP)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 04-1590850-083	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 434158

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-OD (PREMIER GLOBAL)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 04-1590850-098	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 289395

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-PI (GOLD & SPEC MINERALS)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-212	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 17573

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QF (COMMODITY RI RTN STRAT)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-216	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 5323

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QJ (MID CAP VALUE)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-111	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1094

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QL (STRATEGIC INCOME)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 90-0342299-112	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 21622
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-S3 (ONE CHIOCE 2055 PRTFL)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 90-0779283-180	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2822
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-T (MID CAP GR)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 90-0342299-116	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 87164
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-U (GOVERNMENT MONEY MARKET)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 04-1590850-109	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 237072
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-UD (INTERNATIONAL VALUE)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 90-0342299-221	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 707
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-UE (GLOBAL BOND)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 90-0342299-222	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 106
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-VI (LEVERAGE CO STCK)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 04-1590850-363	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3972
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WO (GROWTH)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 04-1590850-112	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 274883
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-W4 (NEW HORIZONS)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 04-1590850-112	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 9578
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-W5 (SPECTRUM GROWTH)		
b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY		
c EIN-PN 04-1590850-117	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 175415

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WZ (SELECT METWEST TOTAL RETURN

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 04-1590850-193	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11401

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-ZA (SMALL COMPANY OPPORTUNITY)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-038	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 746

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-ZH (ONCE CHIOCE 2025 PRTFL)

b Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

c EIN-PN 90-0342299-239	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1760

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

a Plan name	
b Name of plan sponsor	**c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SACHEM DENTAL GROUP, LLP

D Employer Identification Number (EIN)
11-2547652

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	84080	115043
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	4400760	4985982
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	2778417	2494067
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	7263257	7595092
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	0	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	7263257	7595092

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. 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. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	134278	
(B) Participants	2a(1)(B)	277947	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		412225
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	3761	
(F) Other	2b(1)(F)	75193	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		78954
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	237299	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		237299

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		272481
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		1000959
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	624966	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		624966
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		4510
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	39648	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		39648
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		669124
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		331835
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [ ] Unqualified **(2)** [ ] Qualified **(3)** [X] Disclaimer **(4)** [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [X] Yes [ ] No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: IVES & SULTAN LLP **(2)** EIN: 11-2715389

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

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 the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
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 have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	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..... ☐ **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)

5c 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 V Trust Information (optional)

6a Name of trust	**6b** Trust's EIN

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

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
SACHEM DENTAL GROUP, LLP 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SACHEM DENTAL GROUP, LLP

D Employer Identification Number (EIN)
11-2547652

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**

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): 04-1590850

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 (include any prior year accumulated funding deficiency not waived) **6a**

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

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**

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 or other authority 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. 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 lines 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 lines 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 lines 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 lines 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 lines 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 lines 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**	
b The plan year immediately preceding the current plan year	**14b**	
c The second preceding plan year	**14c**	

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**	
b The corresponding number for the second preceding plan year	**15b**	

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**	
b If line 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 lines (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 line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

IVES & SULTAN, LLP
Certified Public Accountants

100 Crossways Park Drive West, Woodbury, NY 11797-2012 516-496-9500 Fax: 516-496-9508

SACHEM DENTAL GROUP 401(K) AND PROFIT SHARING PLAN & TRUST

FINANCIAL STATEMENTS
DECEMBER 31, 2014

SACHEM DENTAL GROUP 401(K) AND PROFIT SHARING PLAN & TRUST

FINANCIAL STATEMENTS
YEAR ENDED DECEMBER 31, 2014

Table of Contents

Financial Statements:

Independent Auditors' Report	1
Statements of Net Assets Available for Benefits	2
Statement of Changes in Net Assets Available for Benefits	3
Notes to Financial Statements	4 – 8
Supplemental Information	9
Schedule of Assets Held for Investment Purposes	10

IVES & SULTAN, LLP
Certified Public Accountants

100 Crossways Park Drive West, Woodbury, NY 11797-2012 516-496-9500 Fax: 516-496-9508

INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
Sachem Dental Group 401(k) and Profit Sharing Plan & Trust
Lake Ronkonkoma, NY

Report on the Financial Statements
We were engaged to audit the financial statements of Sachem Dental Group 401(k) and Profit Sharing Plan & Trust, which comprise of the statement of net assets available for benefits as of December 31, 2014 and 2013, and the related statement of changes in net assets available for benefits for the year ended December 31, 2014, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements
Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of the financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion
As permitted by 29 CFR 2520.103-8 of the Department of Labors Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by Mass Mutual Retirement Services, the trustee of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2014 and 2013 , that the information provided to the plan administrator by the trustee is complete and accurate.

Disclaimer of Opinion
Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Other Matter
The supplemental schedule of assets at fair value are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

Report on Form and Content in Compliance With DOL Rules and Regulations
The form and content of the information included in the financial statements and schedules, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

IVES & SULTAN, LLP
Certified Public Accountants

September 28, 2015

SACHEM DENTAL GROUP 401(K) AND PROFIT SHARING PLAN & TRUST

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31,

	2014	2013
Assets		
Investments, at Fair Value	$7,480,049	$7,179,177
Notes Receivable - Participants	115,043	84,080
Net Assets Available for Benefits	$7,595,092	$7,263,257

See accompanying notes and report on audit of financial statements.

SACHEM DENTAL GROUP 401(K) AND PROFIT SHARING PLAN & TRUST

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEAR ENDED DECEMBER 31, 2014

Additions	
Additions to Net Assets Attributed to:	
Investment Income:	
Interest and Dividends	$ 75,193
Interest on Notes Receivable - Participants	3,761
Net Appreciation on Investments	509,780
	588,734
Contributions:	
Participant	277,947
Employer	134,278
Total Contributions	412,225
Total Additions	1,000,959
Deductions	
Deductions From Net Assets Attributed to:	
Benefits Paid to Participants	(629,476)
Administrative Fees	(39,648)
Total Deductions	(669,124)
Net Increase	331,835
Net Assets Available for Benefits - At Beginning of Year	7,263,257
Net Assets Available for Benefits - At End of Year	$7,595,092

See accompanying notes and report on audit of financial statements.

1. **Description of Plan**

The following description of Sachem Dental Group 401(k) and Profit Sharing Plan & Trust provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

a. **General**

The Plan is a defined contribution plan covering all employees of the Company who are not covered by a collective bargaining agreement and are not a non-resident alien. These employees must have one year of service and have worked 1,000 hours of service. The Plan's sponsor is Sachem Dental group, LLP It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

b. **Contributions**

Each year, participants may contribute a maximum of 15% of their salary, plus a catch-up amount if the participant is age 50 or over. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. Also each year, the Sponsor will contribute to the Plan, a Basic Contribution equal to 100% of the first 3% of salary deferred plus 50% of the next 2% deferred of annual pay. The Sponsor may also make a discretionary Profit Sharing Contribution.

c. **Participant Accounts**

Each participant's account is credited with the employer's contributions and allocations of the Plan earnings. The benefit to which a participant is entitled, is the benefit that can be provided from the participant's vested account.

d. **Vesting**

Participants are immediately vested in the contributions plus actual earnings thereon. Participants shall have a vested percentage in their employer contribution accounts according to a graded vesting schedule based on years of service. A participant is 100% vested after six years of credited service or if the participant becomes disabled or dies during employment.

e. **Participant Loans**

Participants may borrow from their fund accounts a minimum of $1,000 up to the lesser of 50% of their vested account balance or $50,000. If a loan was taken in the previous 12 months, the amount of the highest outstanding loan balance is deductible from the amount the participant may borrow. Loans will be subject to interest charges equal to the annual effective prime rate plus 1%. Loans must normally be repaid within such period as agreed to between the participant and the Plan, up to a maximum of five years. However, if the loan is made for the purchase or construction of a principal place of residence, the repayment period may be up to 30 years. Repayment will normally be made through payroll deductions. Any outstanding loans must be repaid when employment terminates. At December 31, 2014, interest rates ranged from 4.25% to 9.50% per annum, with loans having various maturity dates.

f. **Payment of Benefits**

Participants are eligible to receive benefit payments when they terminate service or reach age 65. On termination of service, a participant may elect to receive an annuity, installment payments or a lump sum amount equal to the participant's account. Benefit payments are also permitted for death, disability or hardship.

2. **Summary of Significant Accounting Policies**

a. **Estimates**

The preparation of financial statements in conformity with generally accepted accounting principles requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

b. **Investment Valuation and Income Recognition**

The Plan's investments are stated at fair value. Quoted market prices are used to value investments. Shares of mutual funds are valued at quoted market prices which represent the net asset value of shares held by the Plan at year-end.

c. **Payments of Benefits**

Benefits are recorded when paid.

d. **Subsequent Events**

Management has evaluated subsequent events through September 28, 2015, the date that the financial statements were available to be issued. No significant material events have been identified that would require adjustment of or disclosure in the accompanying financial statements.

e. **Plan Expenses**

Expenses other than investment management fees are paid directly by the Plan sponsor.

3. **Plan Termination**

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants would become 100% vested in their employer contributions.

4. **Information Prepared and Certified by Trustee**

The following information included in the accompanying financial statements and supplemental schedule was obtained from data that has been prepared and certified to as complete and accurate by Mass Mutual Retirement Services, at December 31, 2014. This information has not been audited by the independent auditors.

Investments, at fair value:	
Mutual Funds	$4,985,982
Group Annuity Contract	2,494,067
	$7,480,049
Interest income from:	
Fixed interest accounts	$ 75,193
Interest on notes receivable from participants	3,761
Total Interest Income	$ 78,954

5. Reconciliation of Financial Statements to Schedule H of Form 5500.

The following is a reconciliation of net assets available for benefits per the financial statements to Schedule H Form 5500.

	December 31, 2014
Net Assets Available for Benefits Per the Financial Statements	$7,595,092
Net Assets Available for Benefits per Schedule H on the Form 5500	$7,595,092

	December 31, 2013
Net Assets Available for Benefits Per the Financial Statements	$7,595,092
Net Assets Available for Benefits per Schedule H on the Form 5500	$7,595,092

6. Fair Value Measurements

FASB Accounting Standards Codification ("ASC") Topic 820, Fair Value Measurements and Disclosures, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 – Inputs to the valuation methodology include:

- quoted prices for similar assets or liabilities in active markets;
- quoted prices for identical or similar assets or liabilities in inactive markets;
- inputs other than quoted prices that are observable for the asset or liability;
- inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

6. Fair Value Measurements (continued)

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

	December 31, 2014			
	Level 1	Level 2	Level 3	Total
Mutual Funds	$4,360,890	-	-	$4,360,890
Money Market Account	625,092	-	-	625,092
	4,985,982	-	-	4,985,982
Guaranteed Interest Account	-	2,494,067	-	2,494,067
Total Assets at Fair Value	$4,985,982	$2,494,067	$ -	$7,480,049

	December 31, 2013			
	Level 1	Level 2	Level 3	Total
Mutual Funds	$3,809,488	-	-	$3,809,488
Money Market Account	591,272	-	-	591,272
	4,400,760	-	-	4,400,760
Guaranteed Interest Account	-	2,778,417	-	2,778,417
Total Assets at Fair Value	$4,400,760	$2,778,417	$ -	$7,179,177

7. Tax Status

The Plan is a prototype plan that has received a determination letter dated January 12, 2004 issued by the National Office of the Internal Revenue Service that the Plain is qualified under Code Section 401. The Plan has been amended since receiving the determination letter; however the Sponsor believes that the Plan is correctly designed and is currently being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the plan and recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS.

The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that at December 31, 2014, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. Generally, tax authorities can examine tax returns filed for the last three years. Currently, there are no ongoing tax examinations that the Plan is aware of.

8. Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the accompanying Statement of Net Assets Available for Benefits and Statements of Changes in Net Assets Available for Benefits.

9. Party-in-Interest Transactions

Certain services are rendered to the Plan by the Company at no cost to the Plan. Certain recordkeeping fees for the Plan were paid to the record keeper directly by a financial institution whose investments were included in the Plan.

SUPPLEMENTAL INFORMATION

Schedule H - PartIV - Line 4i - Schedule of Assets Held for Investment Purposes
Attachment - Form 5500
Plan EIN: 11-2547652

SACHEM DENTAL GROUP 401(k) AND PROFIT SHARING PLAN & TRUST

AT DECEMBER 31, 2014

Identity of Issue	Description of Investment		Current Value
Mass Mutual	Money Market	**	$ 388,020
Mass Mutual	Government Money Market	**	237,072
Mass Mutual	Premier Core Bond	**	318,486
Mass Mutual	Sel Blackrock Global	**	276,890
Mass Mutual	Spectrum Growth	**	175,415
Mass Mutual	Sel Growth Opportunities	**	420,677
Mass Mutual	Growth	**	274,883
Mass Mutual	Premier Oppenheimer Funds Sm Cap	**	434,158
Mass Mutual	Select Focused Value	**	368,739
Mass Mutual	Premier Global	**	289,395
Mass Mutual	Select Overseas	**	72,583
Mass Mutual	Mid Cap Growth	**	87,164
Mass Mutual	Select Fundamental Value	**	51,953
Mass Mutual	Atlanta SMID-Cap	**	159,673
Mass Mutual	Balanced-Risk Allocation	**	909,323
Mass Mutual	Commodity R1 Return Strategic	**	5,323
Mass Mutual	Developing Markets	**	1,334
Mass Mutual	Equity Dividend	**	410,755
Mass Mutual	Global Bond Fund	**	106
Mass Mutual	Gold and Spec Min	**	17,573
Mass Mutual	International Value	**	707
Mass Mutual	Leveraged Common Stock	**	3,972
Mass Mutual	One Choice 2025 Portfolio	**	1,760
Mass Mutual	One Choice 2055 Portfolio	**	2,822
Mass Mutual	Mid Cap Value	**	1,094
Mass Mutual	New Horizons	**	9,578
Mass Mutual	Real Estate	**	32,758
Mass Mutual	Select PIMCO Total Return	**	11,401
Mass Mutual	Small Company Opportunity	**	746
Mass Mutual	Strategic Income	**	21,622
Mass Mutual	Guaranteed Investment Contracts	**	2,494,067
			$ 7,480,049
Notes Recievable from Participants	from 4.25% to 8.5%		$ 115,043
			$ 7,595,092

A Name of Plan	B Three-digit plan Number
Sachem Dental Group, LLP. 401(k) / Profit Sharing Plan	**001**
C Plan sponsor's name as shown on line 2a of Form 5500	**D Employer Identification Number**
Sachem Dental Group, LLP.	**112547652**

Schedule H, line 4i - Schedule of Assets (Held At End of Year)

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest,collateral, par, or maturity value	(d) Cost	(e) Current Value
*	MassMutual	Guaranteed Interest Account	2,256,767	2,256,767
*	MassMutual	Holding Account - SIA-AG	0	388,020
*	MassMutual	SIA-AD	304,232	420,677
*	MassMutual	SIA-AE	274,895	318,485
*	MassMutual	SIA-AH	62,998	72,583
*	MassMutual	SIA-AK	39,664	51,953
*	MassMutual	SIA-AV	177,468	368,739
*	MassMutual	SIA-C2	28,400	32,758
*	MassMutual	SIA-C9	1,409	1,334
*	MassMutual	SIA-CBA	130,725	159,673
*	MassMutual	SIA-CBF	336,956	410,755
*	MassMutual	SIA-CCV	864,941	909,323
*	MassMutual	SIA-LB	183,778	276,889
*	MassMutual	SIA-NM	222,955	434,158
*	MassMutual	SIA-OD	188,986	289,395
*	MassMutual	SIA-PI	24,900	17,573
*	MassMutual	SIA-QF	7,114	5,323
*	MassMutual	SIA-QJ	1,015	1,094
*	MassMutual	SIA-QL	19,426	21,622
*	MassMutual	SIA-S3	2,722	2,822
*	MassMutual	SIA-T	60,603	87,164
*	MassMutual	SIA-U	224,439	237,072
*	MassMutual	SIA-UD	701	707
*	MassMutual	SIA-UE	105	106
*	MassMutual	SIA-VI	3,829	3,972
*	MassMutual	SIA-W0	135,068	274,883
*	MassMutual	SIA-W4	9,501	9,578
*	MassMutual	SIA-W5	131,833	175,415
*	MassMutual	SIA-WZ	11,235	11,401
*	MassMutual	SIA-ZA	709	746
*	MassMutual	SIA-ZH	1,673	1,760
	Participant Loans	4.250000 - 8.500000	0	115,297

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).

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

OMB Nos. 1210-0110
1210-0089

2014

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan (Filers checking this box attach a list of participating employer information in accordance with the form instructions); or
- [x] 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:
- [x] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information --- enter all requested information

1a Name of plan
Sachem Dental Group, LLP 401(k) Profit Sharing Plan

1b Three-digit plan number (PN) ► 002

1c Effective date of plan 01/01/1992

2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)

Sachem Dental Group, LLP

469 Hawkins Avenue

US Lake Ronkonkoma NY 11779

2b Employer Identification Number (EIN) 11-2547652

2c Plan Sponsor's telephone number (631) 588-3674

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	[signature]	10.9.15	Anthony Gowrie
	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 [X] 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:	**4b** EIN	
a Sponsor's name	**4c** PN	
5 Total number of participants at the beginning of the plan year	**5**	123
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	94
a(2) Total number of active participants at the end of the plan year	**6a(2)**	117
b Retired or separated participants receiving benefits	**6b**	
c Other retired or separated participants entitled to future benefits	**6c**	27
d Subtotal. Add lines **6a(2), 6b,** and **6c.**	**6d**	144
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	144
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	107
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	2
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 2K 2T 3B 3D

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

Plan funding arrangement (check all that apply)

9a

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

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) . . . . . ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) . . ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan

Sachem Dental Group, LLP 401(k) Profit Sharing Plan

B Three-digit plan number (PN) ▶ 002

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

Sachem Dental Group, LLP

D Employer Identification Number (EIN)

11-2547652

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

Massachusetts Mutual Life Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
04-1590850	65935	RM 82842-1	102	01/01/2014	12/31/2014

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
35,455	

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

Morgan Stanley Ins Services Inc
34 Exchange Place

US Jersey City NJ 07311

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
35,455			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	2,256,768
5 Current value of plan's interest under this contract in separate accounts at year end	5	4,985,982

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	6d	

Specify nature of costs ▶

e Type of contract (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶

Group Annuity Contract

b Balance at the end of the previous year			7b	2,519,946
c Additions: (1) Contributions deposited during the year	7c(1)	666,155		
(2) Dividends and credits	7c(2)			
(3) Interest credited during the year	7c(3)	75,193		
(4) Transferred from separate account	7c(4)	81,935		
(5) Other (specify below)	7c(5)	31,689		
▶ LN Interest, LN Prin, Loan Default, Trans Assets				
(6) Total additions			7c(6)	854,972
d Total of balance and additions (add lines 7b and 7c(6)).			7d	3,374,918
e Deductions:				
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	555,521		
(2) Administration charge made by carrier	7e(2)	13,847		
(3) Transferred to separate account	7e(3)	543,214		
(4) Other (specify below)	7e(4)	5,568		
▶ LN Dist				
(5) Total deductions			7e(5)	1,118,150
f Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	2,256,768

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify) ▶			

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount			10b	
Specify nature of costs ▶				

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefit Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	2014 This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan	B Three-digit plan number (PN) ▶
Sachem Dental Group, LLP 401(k) Profit Sharing Plan	002

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
Sachem Dental Group, LLP	11-2547652

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions) ..... [X] Yes [ ] No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

Massachusetts Mutual Life Ins. Co. 04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
52 60 63 64 67 68 72	Contract Administrator	36,657	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

United Benefit Pensions Inc. 36-4517541
35 Pinelawn Road
US Melville NY 11747

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	Third Party Administrator	0	Yes [X] No [ ]	Yes [ ] No [X]	2,676	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

The Benefit Practice 13-4144565

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	Third Party Administrator	0	Yes [X] No [ ]	Yes [ ] No [X]	2,636	Yes [ ] No [X]

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:
b EIN:
c Position:
d Address:
e Telephone:

Explanation:

a Name:
b EIN:
c Position:
d Address:
e Telephone:

Explanation:

a Name:
b EIN:
c Position:
d Address:
e Telephone:

Explanation:

a Name:
b EIN:
c Position:
d Address:
e Telephone:

Explanation:

a Name:
b EIN:
c Position:
d Address:
e Telephone:

Explanation:

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

United Benefit Pensions Inc. 36-4517541
35 Pinelawn Road

US Melville NY 11747

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	Third Party Administrator	0	Yes [X] No [ ]	Yes [X] No [ ]	750	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

Morgan Stanley Smith Barney LLC 26-4310632

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	Advisor	0	Yes [X] No [ ]	Yes [ ] No [X]	347	Yes [ ] No [X]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	2014 This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan	B Three-digit plan number (PN) ►	
Sachem Dental Group, LLP 401(k) Profit Sharing Plan		002
C Plan or DFE sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
Sachem Dental Group, LLP	11-2547652	

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AD (Sel Gr Opportunities)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-013	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	420,677
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AE (Premier Core Bond)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-014	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	318,485
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AG (Premier Money Market)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Lifde Insurance Company		
c EIN-PN 04-1590850-016	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	388,020
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AH (Sel Overseas)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-155	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	72,583
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AK (Select Fundamental Val)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-175	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	51,953
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-AV (Select Focused Value)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-027	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	368,739
a Name of MTIA, CCT, PSA, or 103-12 IE:	SIA-C2 (Real Estate)		
b Name of sponsor of entity listed in (a):	Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-272	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	32,758

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-C9 (Developing Market)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0324299-148	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1,334
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CBA (Atlanta Cap SMID-Cap)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0779283-197	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	159,673
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CBF (Equity Dividend)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-363	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	410,755
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-CCV (Balanced-Risk Allocation)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0779283-219	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	909,323
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-LB (Sel BlackRock Global)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-050	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	276,889
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-NM (Prm Oppenheimer Fds Sm Cp)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-083	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	434,158
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-OD (Premier Global)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-098	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	289,395
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-PI (Gold & Spec Minerals)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-212	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	17,573
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QF (Commodity RI Rtn Strat)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-216	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	5,323
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QJ (Mid Cap Value)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-111	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1,094

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-QL (Strategic Income)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-112	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	21,622
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-S3 (One Chioce 2055 Prtfl)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0779283-180	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	2,822
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-T (Mid Cap Gr)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-116	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	87,164
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-U (Government Money Market)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-109	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	237,072
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-UD (International Value)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-221	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	707
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-UE (Global Bond)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 90-0342299-222	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	106
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-VI (Leverage Co Stck)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-363	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	3,972
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WO (Growth)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-112	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	274,883
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-W4 (New Horizons)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-112	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	9,578
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-W5 (Spectrum Growth)			
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company			
c EIN-PN 04-1590850-117	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	175,415

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WZ (Select MetWest Total Return		
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company		
c EIN-PN 04-1590850-193	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11,401
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-ZA (SMall Company Opportunity)		
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company		
c EIN-PN 90-0342299-038	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 746
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-ZH (Once Chioce 2025 Prtfl)		
b Name of sponsor of entity listed in (a): Massachusetts Mutual Life Insurance Company		
c EIN-PN 90-0342299-239	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1,760
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan
Sachem Dental Group, LLP 401(k) Profit Sharing Plan

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
Sachem Dental Group, LLP

D Employer Identification Number (EIN)
11-2547652

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	84,080	115,043
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	4,400,760	4,985,982
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	2,778,417	2,494,067
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	7,263,257	7,595,092
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	0	0
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	7,263,257	7,595,092

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. 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. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	134,278	
(B) Participants	2a(1)(B)	277,947	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A)**, **(B)**, **(C)**, and line **2a(2)**	2a(3)		412,225
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	3,761	
(F) Other	2b(1)(F)	75,193	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		78,954
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	237,299	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		237,299

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		272,481
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		1,000,959
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	624,966	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		624,966
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		4,510
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	39,648	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		39,648
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		669,124
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		331,835
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):
(1) ☐ Unqualified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☒ Yes ☐ No

c Enter the name and EIN of the accountant (or accounting firm) below:
(1) Name: Ives & Sultan LLP (2) EIN: 11-2715389

d The opinion of an independent qualified public accountant is **not attached** because:
(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines **4j** and 4l. MTIAs also do not complete line 4l.

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 participant's account balance. (Attach Schedule G (Form 5500) Part I if **"Yes"** is checked.)	4b		x	

		Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if **"Yes"** is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if **"Yes"** is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500,000
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 have assets held for investment? (Attach schedule(s) of assets if **"Yes"** is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if **"Yes"** is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	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 . . . ☐ **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)

5c 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 V Trust Information (optional)

6a Name of trust	**6b**Trust's EIN

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

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan

Sachem Dental Group, LLP 401(k) Profit Sharing Plan

B Three-digit plan number (PN) ▶ 002

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

Sachem Dental Group, LLP

D Employer identification Number (EIN)

11-2547652

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

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): 04-1590850

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 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 (include any prior year accumulated funding deficiency not waived) 6a

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

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

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 or other authority 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. 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 lines 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 lines 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 lines 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 lines 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 lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

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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 lines 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	
b The plan year immediately preceding the current plan year	14b	
c The second preceding plan year	14c	

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	
b The corresponding number for the second preceding plan year	15b	

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	
b If line 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 lines (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-yeild 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 line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

A Name of Plan	B Three-digit plan Number
Sachem Dental Group, LLP. 401(k) / Profit Sharing Plan	001
C Plan sponsor's name as shown on line 2a of Form 5500	**D Employer Identification Number**
Sachem Dental Group, LLP.	112547652

Schedule H, line 4i - Schedule of Assets (Held At End of Year)

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest,collateral, par, or maturity value	(d) Cost	(e) Current Value
*	MassMutual	Guaranteed Interest Account	2,256,767	2,256,767
*	MassMutual	Holding Account - SIA-AG	0	388,020
*	MassMutual	SIA-AD	304,232	420,677
*	MassMutual	SIA-AE	274,895	318,485
*	MassMutual	SIA-AH	62,998	72,583
*	MassMutual	SIA-AK	39,664	51,953
*	MassMutual	SIA-AV	177,468	368,739
*	MassMutual	SIA-C2	28,400	32,758
*	MassMutual	SIA-C9	1,409	1,334
*	MassMutual	SIA-CBA	130,725	159,673
*	MassMutual	SIA-CBF	336,956	410,755
*	MassMutual	SIA-CCV	864,941	909,323
*	MassMutual	SIA-LB	183,778	276,889
*	MassMutual	SIA-NM	222,955	434,158
*	MassMutual	SIA-OD	188,986	289,395
*	MassMutual	SIA-PI	24,900	17,573
*	MassMutual	SIA-QF	7,114	5,323
*	MassMutual	SIA-QJ	1,015	1,094
*	MassMutual	SIA-QL	19,426	21,622
*	MassMutual	SIA-S3	2,722	2,822
*	MassMutual	SIA-T	60,603	87,164
*	MassMutual	SIA-U	224,439	237,072
*	MassMutual	SIA-UD	701	707
*	MassMutual	SIA-UE	105	106
*	MassMutual	SIA-VI	3,829	3,972
*	MassMutual	SIA-W0	135,068	274,883
*	MassMutual	SIA-W4	9,501	9,578
*	MassMutual	SIA-W5	131,833	175,415
*	MassMutual	SIA-WZ	11,235	11,401
*	MassMutual	SIA-ZA	709	746
*	MassMutual	SIA-ZH	1,673	1,760
	Participant Loans	4.250000 - 8.500000	0	115,297