Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

| 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) QUENTIN M. MURPHY, DDS 2b Employer Identification Nu (EIN) 13-3132816 2c Sponsor's telephone number (employer, if for a single-employer plan) 914-337-1004 | Part I | | t identification information | n | | | | | |
|--|--------------------------------------|--|--|--|-----------------------------|-------------------------|----------------------|--|--|
| A This return/report is for: a one-participant plan a foreign plan a foreign plan a foreign plan a foreign plan the first return/report the first return/report the first return/report a short plan year return/report (less than 12 months) C Check box if filing under: Form 5558 automatic extension DFVC program | For calend | dar plan year 2014 or | | <u>2014</u> | and ending 10 | 0/31/2015 | | | |
| B This return/report is | A This re | eturn/report is for: | X a single-employer plan | | | | | | |
| an amended return/report a short plan year return/report (less than 12 months) C C Check box if filing under: Form 5558 automatic extension DFVC program Part II Basic Plan Information—enter all requested information 1a Name of plan QUENTIN M. MURPHY, DDS PC PROFIT SHARING PLAN 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) QUENTIN M. MURPHY, DDS PC PROFIT SHARING PLAN 2b Employer Identification Nu (EIN) 13-3132816 2c Sponsor's telephone number (PN) 77 PONDFIELD ROAD 2d Business code (see instruct extension) 3a Plan administrator's name and address Same as Plan Sponsor. 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. 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. 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. 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. 5a Total number of participants at the beginning of the plan year. 5b C Number of participants with account balances as of the end of the plan year. 6c Sharp Sharp | | | a one-participant plan | a foreign plan | | | | | |
| C Check box if filing under: | B This return/report is | | the first return/report | the final return/repo | rt | | | | |
| Special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan QUENTIN M. MURPHY, DDS PC PROFIT SHARING PLAN QUENTIN M. MURPHY, DDS PC PROFIT SHARING PLAN QUENTIN M. MURPHY, DDS PC PROFIT SHARING PLAN QUENTIN M. MURPHY, DDS QUENTIN M. | | | an amended return/report | a short plan year re | turn/report (less than 12 m | nonths) | | | |
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| 1 | | | special extension (enter des | cription) | | | | | |
| 1 | Part II | Basic Plan Inf | ormation—enter all requested i | nformation | | | | | |
| Tight Complete C | | | C PROFIT SHARING PLAN | | | plan number | 002 | | |
| CEIN 13-3132816 2c Sponsor's telephone numl 914-337-1004 2d Business code (see instructions) 14-337-1004 2d Business code (see instructions) 2d Business code (see instructions 2d Business code | | | | | | 1c Effective date | | | |
| 2c Sponsor's telephone number 914-337-1004 2d Business code (see instruct 621112 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone in 621112 3c Administrator's name and address Same as Plan Sponsor. 3c Administrator's telephone in 621112 3c Administrator's telephone in 62112 3c Administrator's t | 2a Plan s | sponsor's name and a M. MURPHY, DDS | address; include room or suite num | ber (employer, if for a sing | le-employer plan) | ' ' | | | |
| A 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. 3 b Administrator's telephone is a Sponsor's name 4 c PN 5 a Total number of participants at the beginning of the plan year. 5 a Total number of participants at the end of the plan year. 5 b Total number of participants at the end of the plan year. 5 c Number of participants with account balances as of the end of the plan year. 5 c Number of participants with account balances as of the end of the plan year. 5 c Sold(1) 6 c Number of participants with account balances as of the end of the plan year. 5 c Sold(1) 6 c Number of participants with account balances as of the end of the plan year. 5 c Sold(1) 6 c Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(2) 6 Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(2) 6 Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(2) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of participants during the plan year with accrued benefits that were less than 100% vested. 5 c Sold(3) 6 Number of pa | 77 PONDFIE | ELD ROAD | | | | | | | |
| 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name 5a Total number of participants at the beginning of the plan year | | | | | | | | | |
| 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. 3 Sponsor's name 4 C PN 5a Total number of participants at the beginning of the plan year | 3a Plan a | administrator's name | and address XSame as Plan Spor | nsor. | | 3b Administrator | 's EIN | | |
| name, EIN, and the plan number from the last return/report. a Sponsor's name 5a Total number of participants at the beginning of the plan year | 4 If the | name and/or FIN of t | he nlan sponsor has changed since | e the last return/report file | I for this plan, enter the | 4b EIN | | | |
| b Total number of participants at the end of the plan year | name | e, EIN, and the plan r | | e the last return/report me | a for this plan, enter the | | | | |
| C Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) d(1) Total number of active participants at the beginning of the plan year | 5a Total | number of participan | ts at the beginning of the plan year | | | . 5a | 5 | | |
| d(1) Total number of active participants at the beginning of the plan year | b Total | number of participan | ts at the end of the plan year | | | . 5b | 4 | | |
| d(2) Total number of active participants at the end of the plan year | | | | | | 5c | 4 | | |
| E Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Sct SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge belief, it is true, correct, and complete. SIGN HERE Signature of plan administrator Date Enter name of individual signing as employer or plan semployer or plan semployer. | d(1) To | tal number of active p | participants at the beginning of the | plan year | | 5d(1) | | | |
| Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Sci SS or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge 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 employer or plan si | d(2) To | tal number of active p | participants at the end of the plan y | ear | | 5d(2) | 1 | | |
| Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Sct SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge belief, it is true, correct, and complete. SIGN HERE Signature of plan administrator Date Enter name of individual signing as employer or plan semployer or plan semployer or plan semployer or plan semployer or plan semployer. | | | 1 7 0 | . , | | 5e | | | |
| HERE 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 s | Caution: A Under per SB or Sch | A penalty for the lat nalties of perjury and redule MB completed | e or incomplete filing of this retu other penalties set forth in the instr- and signed by an enrolled actuary, | rn/report will be assess uctions, I declare that I ha | ed unless reasonable ca | port, including, if app | | | |
| Signature of plan administrator SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as plan administrator Date Enter name of individual signing as employer or plan s | SIGN | Filed with authorize | d/valid electronic signature. | | | | | | |
| SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan s | HERE | Signature of plan | administrator | Date | Enter name of individ | dual signing as plan a | administrator | | |
| Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan s | SIGN | | | | | <u> </u> | | | |
| Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's telephone number (of the control of | HERE | Signature of emp | loyer/plan sponsor | Date | Enter name of individ | dual signing as emplo | oyer or plan sponsor | | |
| | Preparer's | | | (include room or suite num | | | | | |

| | Form 5500-SF 2014 | | Page 2 | | | | | |
|------------|--|-------------------------------------|---|---------|------------------------|-----------------|-------------------|-----------|
| b . | Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of a cunder 29 CFR 2520.104-46? (See instructions on waiver eligibility a figure answered "No" to either line 6a or line 6b, the plan cannot the contraction of the plan cannot waited th | an indepe and condi ot use Fo | ndent qualified public accounta tions.) rm 5500-SF and must instead | nt (IQ | PA) Form | 5500. | | No No |
| | f the plan is a defined benefit plan, is it covered under the PBGC in | surance p | orogram (see ERISA section 40 | 121)? . | | Yes | No Not determined | |
| Par | | | | | - | | | |
| | Plan Assets and Liabilities | | (a) Beginning of Yea | | - | | (b) End of Year | _ |
| | Fotal plan assets | 7a | 4209 | 988 | | | 396422 | |
| | Fotal plan liabilities | 7b | 4200 | 100 | | | 206422 | |
| | Net plan assets (subtract line 7b from line 7a) | 7c | 4209 | 100 | | | 396422 | |
| | ncome, Expenses, and Transfers for this Plan Year | | (a) Amount | | | | (b) Total | |
| | Contributions received or receivable from: 1) Employers | 8a(1) | | | | | | |
| | 2) Participants | 8a(2) | | | | | | |
| | 3) Others (including rollovers) | 8a(3) | | | | | | |
| | Other income (loss) | 8b | 3- | 394 | | | | |
| | Fotal income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | -894 | _ |
| | Benefits paid (including direct rollovers and insurance premiums | | | | | | | |
| t | o provide benefits) | 8d | 236 | 527 | | | | |
| _ e (| Certain deemed and/or corrective distributions (see instructions) | 8e | | | | | | |
| <u>f</u> | Administrative service providers (salaries, fees, commissions) | 8f | | 45 | | | | |
| g | Other expenses | 8g | | | | | | |
| <u>h</u> | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | | 23672 | |
| <u>_i_</u> | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | -24566 | |
| <u>j</u> . | Transfers to (from) the plan (see instructions) | 8j | | | | | | |
| b Part | 2A 2E 3D If the plan provides welfare benefits, enter the applicable welfare fe V Compliance Questions | eature cod | les from the List of Plan Charad | cterist | ic Coc | les in t | he instructions: | |
| 10 | During the plan year: | | | | Yes | No | Amount | |
| a b | Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu Were there any nonexempt transactions with any party-in-interest | ıciary Cor | rection Program) | 10a | | X | | |
| | on line 10a.) | ` | • | 10b | | X | | |
| C | Was the plan covered by a fidelity bond? | | | 10c | X | | 19000 | JO |
| d | Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty? | | | 10d | | Χ | | |
| e | Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.) | of the ber | efits under the plan? (See | 10e | | X | | |
| f | Has the plan failed to provide any benefit when due under the plan | n? | | 10f | | X | | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as | s of year | end.) | 10g | | X | | |
| h | If this is an individual account plan, was there a blackout period? (2520.101-3.) | • | | 10h | | X | | |
| i | If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10 | | | 10i | | | | |
| Part | VI Pension Funding Compliance | | | | | | | |
| 11 | Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below) | | | | | | | No |
| 11a | Enter the unpaid minimum required contribution for current year from | om Sched | dule SB (Form 5500) line 39 | | | 11a | | |
| 12 | Is this a defined contribution plan subject to the minimum funding | requirem | ents of section 412 of the Code | or se | ction : | 302 of | ERISA? Yes X N | No |
| | (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, | | | | | | | |
| а | If a waiver of the minimum funding standard for a prior year is being ranting the waiver. | - | | | , and e | enter th Day | | |

| | Form 5500-SF 2014 | Page 3 - 1 | | | | | |
|------|---|----------------------------|----------------------|---------|---------|-----------------|------|
| lf : | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For | m 5500), and skip to lin | e 13. | | | | |
| b | Enter the minimum required contribution for this plan year | | | 12b | | | |
| | | | | | | | |
| С | Enter the amount contributed by the employer to the plan for this plan year | | | 12c | | | |
| d | Subtract the amount in line 12c from the amount in line 12b. Enter the result negative amount) | | | 12d | | | |
| е | Will the minimum funding amount reported on line 12d be met by the funding | deadline? | | | Yes | No | N/A |
| Part | VII Plan Terminations and Transfers of Assets | | | | | | |
| 13a | Has a resolution to terminate the plan been adopted in any plan year? | | | Y | es X No | | |
| | If "Yes," enter the amount of any plan assets that reverted to the employer the | nis year | | 13a | | | |
| b | Were all the plan assets distributed to participants or beneficiaries, transferred the PBGC? | | • | ontrol | | Yes | (No |
| С | If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.) | in to another plan(s), ide | ntify the plan(s) to |) | | | |
| 1 | 3c(1) Name of plan(s): | | 130 | c(2) EI | N(s) | 13c(3) P | N(s) |
| | | | | | | | |
| | | | 1 | | | l | |

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to **Public Inspection**

| Part I Annual Report | ut lalametélastian Information | | | |
|--|--|--|--|--|
| | rt Identification Information | l | | |
| For calendar plan year 2014 or | fiscal plan year beginning | 11/01/2014 and ending | 10/31/2015 | |
| | X a single-employer plan | a multiple-employer plan (not multiemployer) | (Filers checking this box m | ust attach a list |
| A This return/report is for: | a one-participant plan | of participating employer information in accordance a foreign plan | dance with the form instruc | cuons) |
| | 모 | 按 | | |
| 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 n | nonths) | |
| C Check box if filing under: | X Form 5558 | automatic extension | DFVC program | |
| | special extension (enter desc | ription) | | |
| Part II Basic Plan In | formation—enter all requested in | formation | | |
| | Torritation of the Control of the Co | | 1b Three-digit | |
| 1a Name of plan | DDC DC Drofit Charin | r Dlan | plan number 00 | 2 |
| Quentin M. Murphy, | DDS PC Profit Sharing | d Lram | (PN) Þ | _ |
| | | | 1c Effective date of pla | an |
| | | | 11/01/1999 | |
| 2a Plan sponsor's name and | address; include room or suite numb | per (employer, if for a single-employer plan) | 2b Employer Identifica | tion Number |
| Quentin M. Murphy, | | | (EIN) 13-31328 | 316 |
| | | | 2c Sponsor's telephor | ne number |
| 77 Pondfield Road | | | 914-337-1004 | |
| , . | | | 2d Business code (see | |
| _ | 10000 | | 621112 | o manuomona, |
| Bronxville | NY 10708 | | | |
| 3a Plan administrator's name | and address XSame as Plan Spon | sor. | 3b Administrator's EIN | , |
| | | | 9 | |
| | | | 3c Administrator's tele | pnone number |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 4 If the name and/or EIN of | the plan enoneor has changed since | the last return/report filed for this plan, enter the | 4b EIN | |
| | number from the last return/report. | the lager old this operation of this plant, since | | |
| a Sponsor's name | Tambor Hom Moradi Total Total Total | | 4c PN | |
| | | | 46 PN | |
| 29 LOTST URUSPED OF her richer | ate at the heginning of the plan year | | | |
| | - · · · · · · · · · · · · · · · · · · · | | 5a | 5 |
| • • | nts at the end of the plan year | | 5a | 5 |
| C Number of participants wi | nts at the end of the plan year ith account balances as of the end of | f the plan year (defined benefit plans do not | 5a | |
| C Number of participants win complete this item) | nts at the end of the plan yearthe account balances as of the end of | f the plan year (defined benefit plans do not | 5a 5b 5c | 4 |
| C Number of participants wire complete this item) d(1) Total number of active | nts at the end of the plan yearthat account balances as of the end of | f the plan year (defined benefit plans do not | 5a 5b 5c 5d(1) | 4 |
| C Number of participants wire complete this item) d(1) Total number of active d(2) Total number of active | nts at the end of the plan year ith account balances as of the end of participants at the beginning of the p participants at the end of the plan ye | f the plan year (defined benefit plans do not plan year | 5a 5b 5c | 4 |
| c Number of participants wincomplete this item) | nts at the end of the plan year | f the plan year (defined benefit plans do not | 5a 5b 5c 5d(1) | 4 |
| c Number of participants wincomplete this item) | nts at the end of the plan year ith account balances as of the end of participants at the beginning of the p participants at the end of the plan year at terminated employment during the | f the plan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e | 4 |
| c Number of participants wincomplete this item) | nts at the end of the plan year | the plan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e | 4 4 3 |
| c Number of participants wincomplete this item) | nts at the end of the plan year | olan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e suse is established. | 4 4 1 0 |
| c Number of participants wincomplete this item) | nts at the end of the plan year | the plan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e suse is established. | 4 4 1 0 |
| C Number of participants wire complete this item) | nts at the end of the plan year | olan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e suse is established. eport, including, if applicable, and to the best of my kn | 4 4 1 0 |
| C Number of participants wincomplete this item) | nts at the end of the plan year | the plan year (defined benefit plans do not plan year | 5a 5b 5c 5d(1) 5d(2) 5e suse is established. eport, including, if applicable rt, and to the best of my kn | 4 4 1 0 e, a Schedule owledge and |
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|----|--|------------|---------------------------------|---------|--------------|------------|-------------------|
| a | Were all of the plan's assets during the plan year invested in eligible | le assets? | (See instructions.) | | | | X Yes No |
| | Are you claiming a waiver of the annual examination and report of a under 29 CFR 2520.104-46? (See instructions on waiver eligibility a if you answered "No" to either line 6a or line 6b, the plan cannot be under the contract of the contract of the plan cannot be under the contract of th | n n | | | | | |
| C | if the plan is a defined benefit plan, is it covered under the PBGC in | | | | | | No Not determined |
| a | rt III Financial Information | | | | | | |
| , | Plan Assets and Liabilities | | (a) Beginning of Yea | r | | | (b) End of Year |
| а | Total plan assets | 7a | 42 | 2098 | 8 | | 396422 |
| b | Total plan liabilities | 7b | | | | | |
| C | Net plan assets (subtract line 7b from line 7a) | 7c | 42 | 2098 | 8 | | 396422 |
| } | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | | | | (b) Total |
| а | Contributions received or receivable from: | 0 (4) | | | | | |
| | (1) Employers | 8a(1) | | | + | | |
| | (2) Participants | 8a(2) | | | +- | | |
| | (3) Others (including rollovers) | 8a(3) | | -89 | 4 30 | | |
| | Other income (loss) | 8b | | -67 | - | | -894 |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | + | 12 14 15 T | |
| a | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 2 | 2362 | 7 | | |
| e | Certain deemed and/or corrective distributions (see instructions) | 8e | | | 1 22.5 | 14. F | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | | 4 | 5 | | |
| a | Other expenses | 8g | | | | 17 474 1 | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | | 23672 |
| i | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | -24566 |
| j | Transfers to (from) the plan (see instructions) | 81 | | | | | |
| >a | rt IV Plan Characteristics | <u> </u> | | | | | |
| | If the plan provides pension benefits, enter the applicable pension 2A 2E 3D | feature co | des from the List of Plan Chara | acteris | tic Co | des in | the instructions: |
| b | If the plan provides welfare benefits, enter the applicable welfare for | eature cod | es from the List of Plan Charac | teristi | c Cod | es in th | ne instructions: |
| ar | t V Compliance Questions | | | | | | |
| 0 | During the plan year: | | | | Yes | No | Amount |
| | Was there a failure to transmit to the plan any participant contribu 29 CFR 2510,3-102? (See instructions and DOL's Voluntary Fide | uciary Con | rection Program) | 10a | | х | |
| | Were there any nonexempt transactions with any party-in-interest on line 10a.) | | , | 10b | -1- | X | |
| | Was the plan covered by a fidelity bond? | | | 10c | Х | | 190000 |
| | Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty? | | ************** | 10d | | х | |
| e | Were any fees or commissions paid to any brokers, agents, or of insurance service, or other organization that provides some or all instructions.) | of the ben | efits under the plan? (See | 10e | | х | |
| f | Has the plan failed to provide any benefit when due under the pla | | | 10f | | х | |
| | Did the plan have any participant loans? (If "Yes," enter amount a | | | 10g | | Х | |
| ł | If this is an individual account plan, was there a blackout period? 2520.101-3.) | | | 10h | | Х | |
| İ | If 10h was answered "Yes," check the box if you either provided to exceptions to providing the notice applied under 29 CFR 2520.10 | he require | d notice or one of the | 10i | | | |
| | W. Donaion Funding Compliance | | | | | | |

| Part | VI | Pension Funding Compliance |
|------|----------------|--|
| 11 | | is a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form)) and line 11a below) |
| 11a | Ente | er the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 |
| 12 | ls th | nis a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? Yes 🗓 No |
| | (lf "\ | 'es," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) |
| а | if a v gran | waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling the waiverMonth Day Year |

Part III

7

Part IV

Part V

10

| | Form 5500-SF 2014 | Page 3 - | | | |
|-------------|--|---|----------------|-------------|--------------|
| If | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For | m 5500), and skip to line 13. | | | |
| b | Enter the minimum required contribution for this plan year | | 12b | 1 | |
| | | | | | |
| С | Enter the amount contributed by the employer to the plan for this plan year | *************************************** | 12c | | |
| d | Subtract the amount in line 12c from the amount in line 12b. Enter the result negative amount) | , | 1 120 | | |
| е | Will the minimum funding amount reported on line 12d be met by the funding | g deadline? | | Yes | No N/A |
| Part | VII Plan Terminations and Transfers of Assets | | | | |
| 13a | Has a resolution to terminate the plan been adopted in any plan year? | 12 | | Yes X N | 0 |
| | if "Yes," enter the amount of any plan assets that reverted to the employer th | nis year | 13a | | |
| b | Were all the plan assets distributed to participants or beneficiaries, transferrof the PBGC? | | er the control | | Yes X No |
| C | If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.) | | ian(s) to | | |
| | 13c(1) Name of plan(s): | | 13c(2) f | IN(s) | 13c(3) PN(s) |
| | NIII Took Information (antique) | | | | |
| | VIII Trust Information (optional) | | 1/h | Trust's EIN | |
| 148 | Name of trust | | 170 | irusts Eilv | |