

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 2015 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2015 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) _____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input checked="" type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information
1a Name of plan ANTHONY RAMIREZ DDS PC PROFIT SHARING PLAN	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan 01/01/1991
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) ANTHONY RAMIREZ DDS PC 7424 RIDGE BLVD BROOKLYN, NY 11209-2304	2b Employer Identification Number (EIN) 13-3561748
	2c Plan Sponsor's telephone number 212-922-9225
	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.	06/23/2016	ANTHONY RAMIREZ
	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) ALEX GRASSO 355 LEXINGTON AVENUE NEW YORK, NY 10017			Preparer's telephone number 212-922-9225

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v. 150123

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 2
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) 2
a(2) Total number of active participants at the end of the plan year	6a(2) 2
b Retired or separated participants receiving benefits.....	6b 0
c Other retired or separated participants entitled to future benefits.....	6c 0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 2
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e 0
f Total. Add lines 6d and 6e	6f 2
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 2
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 1A 2E	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input checked="" type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
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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 2015 Form M-1 annual report. If the plan was not required to file the 2015 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 I (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information—Small Plan This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 <div style="font-size: 24pt; font-weight: bold;">2015</div> This Form is Open to Public Inspection
For calendar plan year 2015 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007		
A Name of plan ANTHONY RAMIREZ DDS PC PROFIT SHARING PLAN	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 ANTHONY RAMIREZ DDS PC	D Employer Identification Number (EIN) 13-3561748	

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

<div style="display: inline-block; width: 80px; border: 1px solid black; font-weight: bold; padding: 2px;">Part I</div> Small Plan Financial Information			
Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.			
1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	357768	418564
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a)	1c	357768	418564
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable:			
(1) Employers	2a(1)	20479	
(2) Participants	2a(2)	0	
(3) Others (including rollovers)	2a(3)	0	
b Noncash contributions	2b	0	
c Other income	2c	40317	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		60796
e Benefits paid (including direct rollovers)	2e	0	
f Corrective distributions (see instructions)	2f	0	
g Certain deemed distributions of participant loans (see instructions)	2g	0	
h Administrative service providers (salaries, fees, and commissions)	2h	0	
i Other expenses	2i	0	
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		0
k Net income (loss) (subtract line 2j from line 2d)	2k		60796
l Transfers to (from) the plan (see instructions)	2l		0
3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.			
		Yes	No
a Partnership/joint venture interests	3a	X	
b Employer real property	3b	X	
c Real estate (other than employer real property)	3c	X	
d Employer securities	3d	X	
e Participant loans	3e	X	

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

Part II Compliance Questions

4 During the plan year:	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X		
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance		X		
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)		X		
e Was the plan covered by a fidelity bond?		X		
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X		
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X		
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)		X		
l Has the plan failed to provide any benefit when due under the plan?		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X		
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3		X		
o Did the plan trust incur unrelated business taxable income?		X		
p Were in-service distributions made during the plan year?		X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ Yes ☒ No Amount:**5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

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 III **Trust Information****6a** Name of trust**6b** Trust's EIN**6c** Name of trustee or custodian**6d** Trustee's or custodian's telephone number

ALEXANDER A. GRASSO
ATTORNEY AT LAW
355 LEXINGTON AVENUE, 10TH FLOOR
NEW YORK, NEW YORK 10017-6603
212/922-9225
Fax 212/922-2817
E-mail: alexgrasso@aol.com

June 23, 2016

Department of the Treasury
Department of Labor
Employee Benefits Security Administration

Re: Taxpayer: ANTHONY RAMIREZ DDS PC
SS#: 13-3561748
Tax Year: 1999, 2003, 2004, 2005, 2006, 2007, 2008
2009, 2010, 2011, 2012
Form: 5500 Series
Request to Abate Penalty
For Reasonable Cause

Dear Sirs,

In response to your request, we submit the following reply:

The taxpayer has a small group, only 2 -3 participants, since inception.

This retirement plan was managed by Polaris Investment Partners Inc., who made all the investments and did all of the accounting and management for this plan.

The taxpayer was under the assumption that Polaris was submitting all of the required filings, as they had not been informed of the filing requirement.

The account has never exceeded \$500,00.00

The officers of the taxpayer have never withdrawn any funds or participated in any prohibited transactions.

There was no intention to conceal any transactions or wrongdoing.

The omission to file was an honest and inadvertent error on the part of the taxpayer.

They are now aware of the requirement to file annually.

The taxpayer has now filed all required past returns, and will timely file all future returns.

In light of the information provided above, please adjust your records accordingly. If you have any questions, please do not hesitate to contact me.

Very truly yours,

Alexander A. Grasso, Esq.

AAG/db

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089**2015****This Form is Open to Public Inspection****Part I Annual Report Identification Information**

For calendar plan year 2015 or fiscal plan year beginning 01/01/2007

and ending 12/31/2007

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☒ a single-employer plan;☐ a DFE (specify) _____☐ the first return/report;☐ the final return/report;☐ an amended return/report;☐ a short plan year return/report (less than 12 months).**C** If the plan is a collectively-bargained plan, check here.▶ ☐**D** Check box if filing under:☐ Form 5558;☐ automatic extension;☐ special extension (enter description)☒ the DFVC program;**Part II Basic Plan Information**—enter all requested information**1a** Name of plan

ANTHONY RAMIREZ DDS PC PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 001**1c** Effective date of plan 01/01/1991**2a** Plan sponsor's name (employer, if for a single-employer plan)

Mailing address (include room, apt., suite no. and street, or P.O. Box)

City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

ANTHONY RAMIREZ DDS PC

2b Employer Identification Number (EIN) 13-3561748**2c** Plan Sponsor's telephone number 212-922-92257424 RIDGE BLVD
BROOKLYN, NY 11209-23047424 RIDGE BLVD
BROOKLYN, NY 11209-2304**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 of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Cathary Ramrez</i>	1/23/16	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as DFE
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)		Preparer's telephone number	
ALEX GRASSO		212-922-9225	
355 LEXINGTON AVENUE NEW YORK, NY 10017			

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