Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Short Form Annual Return/Report of Small Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

For calcindar plan year 2017 or fiscal plan year beginning 0101/2017 A This return/report is for: a single-employer plan a multiple employer plan (of multipumployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) This return/report is a nee-participant plan a foreign plan	Parti	Annual Repor	t identification information								
A This return/report is for: a one-participant plan of oreign plan of oreign plan of oreign plan of oreign plan B This return/report de first return/report de first return/report de first return/report de short plan year return/report (less than 12 months)	For calenda	r plan year 2017 or t	iscal plan year beginning 01/01/2	2017	and ending 12	2/31/2017					
B This return/report is	A This retu	urn/report is for:	X a single-employer plan			_					
In the Isr return/report In the Intal return/report Intal retur	D		a one-participant plan	a foreign plan							
C Check box if filing under:	B This retu	rn/report is	X the first return/report	the final return/report							
Special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan			an amended return/report	a short plan year retu	rn/report (less than 12 mo	onths)					
Part II Basic Plan Information—enter all requested information 1a Name of plan 1a Name of plan 1b Three-digit plan number (PN) 001 1c Effective date of plan 0/10/12/017 2a Plan sponsor's name (employer, if for a single-employer plan) 1c Effective date of plan 0/10/12/017 2b Employer Identification Number (EIN) 52/2552/007 2c Sponsor's telephone number 718-667-3800 2d Business code (see instructions) 2d Business c	C Check b	ox if filing under:	Form 5558	automatic extension	[DFVC program					
The name and/or EIN of the plan sponsor's name and address Same as Plan Sponsor.			special extension (enter desc	ription)							
Palan number Palan sponsor's name (employer, if for a single-employer plan) Representation Palan sponsor's name (employer, if for a single-employer plan) Mailing address (includer 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) 2b Employer Identification Number (EIN) 82-2582807 2c Sponsor's telephone number 718-667-3900 2d Business code (see instructions) 490210 STETER STATEN ISLAND, NY 10312 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3trates Administrator's telephone number 4d PN 2d PN	Part II	Basic Plan Info	ormation—enter all requested in	formation							
Palan number Palan sponsor's name (employer, if for a single-employer plan) Representation Palan sponsor's name (employer, if for a single-employer plan) Mailing address (includer 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) 2b Employer Identification Number (EIN) 82-2582807 2c Sponsor's telephone number 718-667-3900 2d Business code (see instructions) 490210 STETER STATEN ISLAND, NY 10312 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3trates Administrator's telephone number 4d PN 2d PN	1a Name o	of plan				1b Three-digi	t				
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) WILLIAM F EDWARDS DDS PC 4300 HYLAND BLVD STE 2E STATEN ISLAND, NY 10312 3a Plan administrator's name and address X Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. 5 Administrator's telephone number 7 18-667-3900 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. 5 Administrator's telephone number 6 Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. 5 Total number of participants at the beginning of the plan year 6 Plan Name 5 Total number of participants at the beginning of the plan year 7 Number of participants at the beginning of the plan year 8 Description of participants with account balances as of the end of the plan year. 6 Number of participants with account balances as of the end of the plan year. 6 Number of participants who terminated employment during the plan year with accrued benefits that were less complete this item). 6 Number of participants who terminated employment during the plan year with accrued benefits that were less for an 100% vested. 7 Sepansor of participants who terminated employment during the plan year with accrued benefits that were less followed and signed by an enrolled actuary, as well as the electronic version of this return/report, including, if applicable, a Schedule Bor Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete filling of this return/report will be assessed unless reasonable cause is established. 7 Sepandor of plan administrator 8 Date Enter name of individual signing as plan admin							per				
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) WILLIAM FEDWARDS DDS PC 2d Business code (see instructions) 2d Business code (see instructions) 2d Business code (see instructions) 3p Plan administrator's name and address Size as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filled for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. c Plan Name 5b Total number of participants at the end of the plan year. 5c Number of participants with account belances as of the end of the plan year. 6d(1) Total number of active participants at the beginning of the plan year. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year wit					_	(PN) ▶	001				
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) 2						•					
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) 2	2a Plan sp	onsor's name (empl	over, if for a single-employer plan)			2b Employer	Identification Number				
### Sponsor's telephone number 118-667-3900 ### 25 Sponsor's telephone number 118-667-3900 ### 2210 ###	Mailing	address (include roo	om, apt., suite no. and street, or P.C								
2dd Business code (see instructions) 492210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. 5b 1 b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(1) Total number of active participants at the beginning of the plan year. 5d(1) 1 d(2) Total number of participants who 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. Signature of plan administrator Date Enter name of individual signing as plan administrator Signature of plan administrator	-		ce, country, and ZIP or foreign post	tal code (if foreign, see ins	tructions)						
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. 5 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 4d PN 5a Total number of active participants at the beginning of the plan year. 5 Number of participants at the beginning of the plan year. 5 Number of participants at the end of the plan year. 5 Number of participants at the beginning of the					-						
The name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name. EIN, the plan name and the plan number from the last return/report. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 5 Sponsor's name C Plan Name 5 Total number of participants at the beginning of the plan year	4300 HYLANI	O BLVD									
3b Administrator's EIN 3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year	STE 2E						492210				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filled for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year	STATENISLA	AND, NY 10312									
4b EIN 4d PN 5a Total number of participants at the beginning of the plan year	3a Plan ad	lministrator's name a	and address X Same as Plan Spo	nsor.		3b Administra	itor's EIN				
4b EIN 4d PN 5a Total number of participants at the beginning of the plan year			_		-						
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year						3c Administra	itor's telephone number				
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year											
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year											
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year											
a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year						4b EIN					
Total number of participants at the beginning of the plan year	•		onsor's name, EIN, the plan name a	and the plan number from	ne last return/report.	Ad DN					
5a Total number of participants at the beginning of the plan year	•					TU FN					
b Total number of participants at the end of the plan year	C Flail No	anie									
C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(1) Total number of active participants at the beginning of the plan year	5a Total n	umber of participant	s at the beginning of the plan year.			5a	1				
d(1) Total number of active participants at the beginning of the plan year	b Total n	umber of participant	s at the end of the plan year			5b	1				
d(1) Total number of active participants at the beginning of the plan year	C Number of participants with account balances as of the end of the plan year (only defined contribution plans				= -	5c	1				
Provided the state of participants who 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 Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN HERE Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator Date	•			The state of the s	5d(1)	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 Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN HERE Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator SIGN HERE	d(2) Total number of active participants at the end of the plan year				5d(2)	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 Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN HERE Signature of plan administrator Date Enter name of individual signing as plan administrator				5e	0						
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete. SIGN HERE Filed with authorized/valid electronic signature. O6/11/2018 EDWARD ROJAS Signature of plan administrator Date Enter name of individual signing as plan administrator	Caution: A	penalty for the late	or incomplete filing of this return	n/report will be assessed	l unless reasonable cau	se is establishe	ed.				
belief, it is true, correct, and complete. SIGN Filed with authorized/valid electronic signature. Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE											
SIGN HERE Filed with authorized/valid electronic signature. O6/11/2018 EDWARD ROJAS Enter name of individual signing as plan administrator SIGN HERE				as well as the electronic ve	ersion of this return/report	, and to the best	of my knowledge and				
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE		· ·		00/4//00/0							
Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE	0.0	Filed with authorize	d/valid electronic signature.	06/11/2018	EDWARD ROJAS						
HERE	HERE	Signature of plan	administrator	Date	Enter name of individu	Enter name of individual signing as plan administrator					
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	SIGN										
	HERE	Signature of empl	oyer/plan sponsor	Date	Enter name of individu	ual signing as em	nployer or plan sponsor				

Form 5500-SF 2017 Page **2**

	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)						Yes No		
	If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. C If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.								
Pa	t III Financial Information		Γ						
7	7 Plan Assets and Liabilities (a) Beginning of Year (b) End							nd of Year	Ť
a	Total plan assets	. 7a		0					52
b	Total plan liabilities	. 7b		0					0
<u>C</u>	Net plan assets (subtract line 7b from line 7a)	7c		0					52
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Total	
a	Contributions received or receivable from: (1) Employers	. 8a(1)		0					
	(2) Participants	8a(2)		52					
	(3) Others (including rollovers)	. 8a(3)		0					
<u>b</u>	Other income (loss)	. 8b		0					
<u> </u>	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							52
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d		0					
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	. 8e		0					
f	Administrative service providers (salaries, fees, commissions)	. 8f		0					
g	Other expenses	. 8g		0					
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	. 8h				0			0
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	. 8i							52
j	Transfers to (from) the plan (see instructions)	· 8j		0					
Pai	Part IV Plan Characteristics								
9a	9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2F 2G 2J 2S 2T 3D								
b	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:								
Par	t V Compliance Questions								
10	During the plan year:				Yes	No		Amoun	t
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)			10a		X			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)			10b		X			
С	C Was the plan covered by a fidelity bond?			10c		Χ			
d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			10d		Х			
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)			10e		X			
f	f Has the plan failed to provide any benefit when due under the plan?			10f		X			
g	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)					Χ			
h	h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			10g 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					

Form 5500-SF 2017	Page 3- 1		
-------------------	------------------	--	--

Part	VI Pension Funding Compliance				
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sci (Form 5500) and line 11a below)	nedule S	B	[] Y	′es X No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	. 11a			
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA?	n 302 o	f 	Y	′es X No
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, ar granting the waiver			of the lette Year _	r ruling
lf y	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				
b Enter the minimum required contribution for this plan year					
C Enter the amount contributed by the employer to the plan for this plan year					
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d			
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?		Ye	s X N	0
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		Yes X No		
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)) to			
13c(1) Name of plan(s): 13c(2)			2) EIN(s) 1:) PN(s)