## Form 5500-SF

Department of the Treasury

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Internal Revenue Service

## 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

| Part I   |  | : Identification Information   | 1                             |                           |  |                                   |  |  |  |
|--|--|--|-------------------------------|---------------------------|--|-----------------------------------|--|--|--|
| For calend   | lar plan year 2017 or f  | iscal plan year beginning 02/01/   | 2017                          | and ending 0              | 1/31/2018  |                                   |  |  |  |
| a single-employer plan  a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) |  |  |                               |                           |  |                                   |  |  |  |
| <b>D</b>   |  | a one-participant plan   | a foreign plan                |                           |  |                                   |  |  |  |
| 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 Check  | box if filing under:   | X Form 5558  | automatic extension           |                           | DFVC progra  | ım                                |  |  |  |
|  |  | special extension (enter desc  | . ,                           |                           |  |                                   |  |  |  |
| Part II  | Basic Plan Info  | ormation—enter all requested in  | formation                     |                           |  |                                   |  |  |  |
| 1a Name<br>MID-HUDS  | •  | FACIAL SURGEONS PC 401K R  | OFIT SHARING PLAN & T         | RUST                      | 1b Three-dig<br>plan num<br>(PN) ▶                         |                                   |  |  |  |
|  |  |  |                               |                           | 1c Effective   | date of plan<br>10/08/1980        |  |  |  |
|  |  | oyer, if for a single-employer plan)   |                               |                           | <b>2b</b> Employer   | Identification Number             |  |  |  |
|  |  | om, apt., suite no. and street, or P.oce, country, and ZIP or foreign pos    |                               | structions)               | (EIN)  | 22-2269680                        |  |  |  |
| -  |  | FACIAL SURGEONS, PC  | tar oodo (ir foreign, ood in  | Structions)               |  | s telephone number<br>45-471-5202 |  |  |  |
|  |  |  |                               |                           | 2d Business code (see instructions)                        |                                   |  |  |  |
| 29 FOX STF   |  |  |                               |                           | 621210   |                                   |  |  |  |
| POUGHKEE   | EPSIE, NY 12601  |  |                               |                           |  |                                   |  |  |  |
| 3a Plan a  | administrator's name a   | nd address X Same as Plan Spo  | neor                          |                           | <b>3b</b> Administra                                       | ator's FIN                        |  |  |  |
| Ou i laire   | danimistrator s name a   | ind address Modifie as Flair ope   | 11301.                        |                           | OD /tariiiilott  | ator o Env                        |  |  |  |
|  |  |  |                               |                           | 3c Administra  | ator's telephone number           |  |  |  |
|  |  |  |                               |                           |  |                                   |  |  |  |
|  |  |  |                               |                           |  |                                   |  |  |  |
| 4 If the   | name and/or EIN of th  | e plan sponsor or the plan name h  | as changed since the last     | return/report filed for   | 4b EIN   |                                   |  |  |  |
| •  |  | onsor's name, EIN, the plan name   | and the plan number from      | the last return/report.   |  |                                   |  |  |  |
| •  | sor's name   |  |                               |                           | 4d PN  |                                   |  |  |  |
| C Plan N   | vame   |  |                               |                           |  |                                   |  |  |  |
| <b>5a</b> Total  | number of participants   | s at the beginning of the plan year  |                               |                           | 5a   | <b>5a</b> 10                      |  |  |  |
| <b>b</b> Total   | number of participants   | s at the end of the plan year  |                               |                           | 5b   | 9                                 |  |  |  |
| <b>C</b> Numb  | per of participants with   | account balances as of the end of  | the plan year (only define    | ed contribution plans     | 5c   | 9                                 |  |  |  |
|  | •  | articipants at the beginning of the p  |                               |                           | 5d(1)  | 5                                 |  |  |  |
| d(2) Total number of active participants at the end of the plan year   |  |  |                               |                           | 5d(2)  | 5                                 |  |  |  |
| Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested  |  |  |                               |                           | 5e   | 0                                 |  |  |  |
| Caution:   | A penalty for the late   | or incomplete filing of this return  | n/report will be assesse      | d unless reasonable car   | use is establish   | ed.                               |  |  |  |
| Under pen<br>SB or Sch   | alties of perjury and o  | ther penalties set forth in the instru<br>and signed by an enrolled actuary, | ctions, I declare that I have | e examined this return/re | port, including, if  | applicable, a Schedule            |  |  |  |
| SIGN   | Filed with authorized  | d/valid electronic signature.  | 11/08/2018                    | JOSEPH PRISCO             |  |                                   |  |  |  |
| HERE   | Signature of plan a  | administrator  | Date                          | Enter name of individ     | lual signing as pl   | an administrator                  |  |  |  |
| SIGN   |  |  |                               |                           |  |                                   |  |  |  |
| HERE   | Signature of emplo   | over/plan sponsor  | Date                          | Enter name of individ     | Enter name of individual signing as employer or plan spons |                                   |  |  |  |

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|          | Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)  |              |                          |               |         |         | X Yes            | No          |           |  |  |
|----------|--|--------------|--------------------------|---------------|---------|---------|------------------|-------------|-----------|--|--|
| b        | Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) |              |                          |               |         |         |                  | X 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.  |              |                          |               |         |         |                  |             |           |  |  |
| С        | If the plan is a defined benefit plan, is it covered under the PBGC in   | nsurance p   | rogram (see ERISA se     | ection 4      | 021)?   |         | Yes No           | Not dete    | ermined   |  |  |
|          | If "Yes" is checked, enter the My PAA confirmation number from the   | e PBGC p     | remium filing for this p | lan yea       | r       |         |                  | (See instru | ictions.) |  |  |
| Pa       | t III Financial Information  |              |                          |               |         |         |                  |             |           |  |  |
| 7        | Plan Assets and Liabilities  |              | (a) Beginning            | of Year       |         |         | (b) End          | l of Year   |           |  |  |
| а        | Total plan assets  | . 7a         | 358                      | 33235         |         |         |                  | 3997379     |           |  |  |
| b        | Total plan liabilities   | . 7b         |                          | 1017          |         |         |                  | 1030        |           |  |  |
| С        | Net plan assets (subtract line 7b from line 7a)  | . 7c         | 358                      | 32218         |         |         |                  | 3996349     |           |  |  |
| 8        | Income, Expenses, and Transfers for this Plan Year   |              | (a) Amoun                | t             |         |         | (b)              | Total       |           |  |  |
| а        | Contributions received or receivable from:   | 0-(4)        |                          | 5070          |         |         |                  |             |           |  |  |
|          | (1) Employers  | 8a(1)        |                          | 5973<br>25595 |         |         |                  |             |           |  |  |
|          | (2) Participants   | 8a(2)        |                          | 0             |         |         |                  |             |           |  |  |
|          | (3) Others (including rollovers)   | 8a(3)        | 40                       | 05767         |         |         |                  |             |           |  |  |
|          | Other income (loss)  | . 8b         | 40                       | 33707         |         |         |                  | 437335      |           |  |  |
|          | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)   | . 8c         |                          |               |         |         |                  | 437333      |           |  |  |
|          | to provide benefits)   | . 8d         |                          | 9386          |         |         |                  |             |           |  |  |
| е        | Certain deemed and/or corrective distributions (see instructions)  | . 8e         |                          | 0             |         |         |                  |             |           |  |  |
| f        | Administrative service providers (salaries, fees, commissions)   | . 8f         | ,                        | 13818         |         |         |                  |             |           |  |  |
| g        | Other expenses   | her expenses |                          |               |         | 0       |                  |             |           |  |  |
| <u>h</u> | Total expenses (add lines 8d, 8e, 8f, and 8g)  | . 8h         |                          |               |         |         |                  | 23204       |           |  |  |
| <u>i</u> | Net income (loss) (subtract line 8h from line 8c)  | . 8i         |                          |               |         |         |                  | 414131      |           |  |  |
| j_       | Transfers to (from) the plan (see instructions)  | 8j           |                          | 0             |         |         |                  |             |           |  |  |
| Par      | t IV Plan Characteristics  |              |                          |               |         |         |                  |             |           |  |  |
| 9a       | If the plan provides pension benefits, enter the applicable pension 2E 2J 2K 3D 2F 2R 2T   | feature co   | des from the List of Pl  | an Cha        | racteri | stic Co | odes in the ins  | tructions:  |           |  |  |
| b        | If the plan provides welfare benefits, enter the applicable welfare for  | eature cod   | les from the List of Pla | n Chara       | acteris | tic Cod | des in the insti | ructions:   |           |  |  |
| Day      | Compliance Oversions   |              |                          |               |         |         |                  |             |           |  |  |
| Par      |  |              |                          |               | Vac     | Na      | 1                |             |           |  |  |
| 10<br>a  | During the plan year:  Was there a failure to transmit to the plan any participant contribu  | ıtione withi | n the time period        |               | Yes     | No      |                  | Amount      |           |  |  |
| u        | described in 29 CFR 2510.3-102? (See instructions and DOL's V  | oluntary F   | iduciary Correction      | 10a           |         | X       |                  |             |           |  |  |
| b        | Were there any nonexempt transactions with any party-in-interest   |              |                          | . 54          |         |         |                  |             |           |  |  |
|          | reported on line 10a.)   |              |                          | 10b           |         | X       |                  |             |           |  |  |
| C        |  |              |                          | 10c           | X       |         |                  | 4000        | 000       |  |  |
| d        | <b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?  |              |                          |               |         | X       |                  |             |           |  |  |
| е        | Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som   |              |                          |               |         |         |                  |             |           |  |  |
|          | the plan? (See instructions.)  |              |                          |               |         | Χ       |                  |             |           |  |  |
| f        | f Has the plan failed to provide any benefit when due under the plan?  |              |                          |               |         | X       |                  |             |           |  |  |
| <u>g</u> |  |              |                          |               |         | X       |                  |             |           |  |  |
| h        | h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)  |              |                          |               |         | 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           |         |         |                  |             |           |  |  |
|          | <del></del>  |              |                          |               |         |         |                  |             |           |  |  |

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|-------------------|------------------|
|-------------------|------------------|

| Part  | VI Pension Funding Compliance   |          |     |        |         |  |  |  |
|---|---|----------|-----|--------|---------|--|--|--|
| 11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) |   |          |     |        |         |  |  |  |
| 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 of |     |        | es X No |  |  |  |
| а   | a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver.  Month Day Year |          |     |        |         |  |  |  |
| 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  | 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 (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?   |          | Yes | X No   | )       |  |  |  |
|   | If "Yes," enter the amount of any plan assets that reverted to the employer this year   | 13a      |     |        |         |  |  |  |
| b   | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?   |          |     | 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     |     |        |         |  |  |  |
| 1   | <b>3c(1)</b> Name of plan(s): 13c(2)  | EIN(s)   |     | 13c(3) | PN(s)   |  |  |  |
|   |   |          |     |        |         |  |  |  |

## Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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).

2017

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection** 

▶ Complete all entries in accordance with the instructions to the Form 5500-SF. **Annual Report Identification Information** For calendar plan year 2017 or fiscal plan year beginning 02/01/2017 and ending 01/31/2018 a multiple-employer plan (not multiemployer) (Filers checking this box must attach a a single-employer plan list of participating employer information in accordance with the form instructions.) A This return/report is for: a one-participant plan a foreign plan B This return/report is the final return/report the first return/report an amended return/report a short plan year return/report (less than 12 months) C Check box if filing under: DFVC program Form 5558 automatic extension special extension (enter description) Basic Plan Information—enter all requested information 1b Three-digit 1a Name of plan plan number MID-HUDSON ORAL & MAXILLOFACIAL SURGEONS PC 401K ROFIT SHARING PLAN & TRUST 001 (PN) > 1c Effective date of plan 10/08/1980 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number Mailing address (include room, apt., suite no. and street, or P.O. Box) (EIN) 22-2269680 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c Sponsor's telephone number MID-HUDSON ORAL & MAXILLOFACIAL SURGEONS, PC (845) 471-5202 2d Business code (see instructions) 621210 29 FOX STREET POUGHKEEPSIE, NY 12601 3b Administrator's EIN 3a Plan administrator's name and address X Same as Plan Sponsor. 3c Administrator's telephone number 4b EIN 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. 4d PN a Sponsor's name C Plan Name 5a 10 5a Total number of participants at the beginning of the plan year ...... 5b 9 **b** Total number of participants at the end of the plan year..... Number of participants with account balances as of the end of the plan year (only defined contribution plans 5c 9 complete this item)..... 5 5d(1) d(1) Total number of active participants at the beginning of the plan year..... 5d(2) 5 d(2) Total number of active participants at the end of the plan year...... Number of participants who terminated employment during the plan year with accrued benefits that were less 0 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. uci. Joseph Prisco SIGN HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE

Date

Signature of employer/plan sponsor

Enter name of individual signing as employer or plan sponsor

| 4      | •   |                          |  |                     |
|--------|---|--------------------------|--|---------------------|
| _      | Form 5500-SF 2017   |                          | Page 2   | <u>_</u>            |
| <br>6a | Were all of the plan's assets during the plan year invested in eligib   | le assets?               | (See instructions.)                            | X Yes No            |
| b      | 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 | an indeper<br>and condit | ndent qualified public accountant (<br>tions.) | IQPA) X Yes No      |
|        | If you answered "No" to either line 6a or line 6b, the plan cann  |                          |  |                     |
| С      | If the plan is a defined benefit plan, is it covered under the PBGC in  |                          |  |                     |
|        | If "Yes" is checked, enter the My PAA confirmation number from the  | e PBGC p                 | remium filing for this plan year               | (See instructions.) |
| Pa     | art III Financial Information   |                          |  |                     |
| 7      | Plan Assets and Liabilities   |                          | (a) Beginning of Year                          | (b) End of Year     |
| а      | Total plan assets   | 7a                       | 3583235  | 3997379             |
| b      | Total plan liabilities  | 7b                       | 1017   | 1030                |
| C      | Net plan assets (subtract line 7b from line 7a)   | 7 <u>c</u>               | 3582218  | 3996349             |
| 8      | Income, Expenses, and Transfers for this Plan Year  |                          | (a) Amount                                     | (b) Total           |
| а      | Contributions received or receivable from:  (1) Employers   | 8a(1)                    | 5973   |                     |
|        | (2) Participants  | 8a(2)                    | 25595  |                     |
|        | (3) Others (including rollovers)  | 8a(3)                    | 0  |                     |
| b      | Other income (loss)   | _8b                      | 405767   | <u> </u>            |
| С      | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)  | 8c                       |  | 437335              |
| d      | Benefits paid (including direct rollovers and insurance premiums to provide benefits)   | 8d                       | 9386   |                     |
| e      | Certain deemed and/or corrective distributions (see instructions)   | 8e                       | 0  |                     |
| f      | Administrative service providers (salaries, fees, commissions)  | 8f                       | 13818  | ži povoj            |

## Part IV | Plan Characteristics

g Other expenses.....

h Total expenses (add lines 8d, 8e, 8f, and 8g).....

Net income (loss) (subtract line 8h from line 8c).....

Transfers to (from) the plan (see instructions) ......

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2J 2K 3D 2F 2R 2T

8<u>g</u>

8h

8i

0

0

23204

414131

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

Part V Compliance Questions

| 10 | During the plan year:  |     |   | No | Amount |
|----|--|-----|---|----|--------|
| а  | Was there a failure to transmit to the plan any participant contributions within the time period descr bed in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)                       | 10a |   | x  |        |
| b  |  | 10b |   | X  |        |
| С  | Was the plan covered by a fidelity bond?   | 10c | X |    | 400000 |
| 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  | Has the plan failed to provide any benefit when due under the plan?  | 10f |   | Х  |        |
| g  | Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)  | 10g |   | Х  |        |
| h  | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)  | 10h |   | Х  | * .    |
| i  | If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3   | 10i |   |    |        |

| Form |  |  |
|------|--|--|
|      |  |  |
|      |  |  |

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|------|----|---|
|      |    |   |

| Part | VI Pension Funding Compliance   |         |       |                       |        |
|------|---|---------|-------|-----------------------|--------|
| 11   | Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sche (Form 5500) and line 11a below)   |         |       | Ye                    | s 🗌 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?  | 302 of  | f<br> | Ye                    | s 🛭 No |
| а    | If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver  | enter t |       | of the letter<br>Year | ruling |
| lf   | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.  |         |       |                       |        |
| b    | Enter the minimum required contribution for this plan year  | 12b     |       |                       |        |
|      | Enter the amount contributed by the employer to the plan for this plan year   | 12c     |       |                       |        |
| d    | Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)   | 12d     |       |                       |        |
| 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?   |         | Yes   | X No                  |        |
|      | If "Yes," enter the amount of any plan assets that reverted to the employer this year   | 13a     |       |                       |        |
| b    | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?   |         | [     | Yes 🛛                 | 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      |       |                       |        |
| •    | 3c(1) Name of plan(s): 13c(2)   | EIN(s)  |       | 13c(3)                | PN(s)  |
|      |   |         |       |                       |        |