

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

2019

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A This return/report is for: 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.)
 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: Form 5558 automatic extension DFVC program
 special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>MERIDIAN PEDIATRIC DENTAL GROUP DEFINED BENEFIT PENSION PLAN & TRUST</u>	1b Three-digit plan number (PN) ▶ <u>002</u>
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) <u>MERIDIAN PEDIATRIC DENTAL GROUP, LLC</u> <u>1922 23RD AVENUE</u> <u>MERIDIAN, MS 39301</u>	1c Effective date of plan <u>01/01/2008</u>
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	2b Employer Identification Number (EIN) <u>45-5149070</u>
	2c Sponsor's telephone number <u>601-482-8986</u>
	2d Business code (see instructions) <u>621210</u>
	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	4b EIN 4d PN
5a Total number of participants at the beginning of the plan year	5a <u>12</u>
b Total number of participants at the end of the plan year	5b <u>12</u>
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c
d(1) Total number of active participants at the beginning of the plan year	5d(1) <u>12</u>
d(2) Total number of active participants at the end of the plan year	5d(2) <u>11</u>
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e <u>1</u>

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.	<u>03/06/2020</u>	<u>J. BRITT MCCARTY, D.M.D.</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 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.) 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.)

Part III Financial Information			
7		(a) Beginning of Year	(b) End of Year
7	Plan Assets and Liabilities		
a	Total plan assets	7a 2272846	2699726
b	Total plan liabilities	7b 0	0
c	Net plan assets (subtract line 7b from line 7a)	7c 2272846	2699726
8		(a) Amount	(b) Total
a	Contributions received or receivable from:		
	(1) Employers	8a(1) 140000	
	(2) Participants	8a(2) 0	
	(3) Others (including rollovers)	8a(3) 0	
b	Other income (loss)	8b 302136	
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	442136
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d 0	
e	Certain deemed and/or corrective distributions (see instructions) ...	8e 0	
f	Administrative service providers (salaries, fees, commissions)	8f 15256	
g	Other expenses	8g 0	
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	15256
i	Net income (loss) (subtract line 8h from line 8c)	8i	426880
j	Transfers to (from) the plan (see instructions)	8j 0	

Part IV Plan Characteristics	
9a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1B 3H
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		Yes	No	Amount
10	During the plan year:			
a	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	
c	Was the plan covered by a fidelity bond?	10c	X	500000
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	X	
e	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	X	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	X	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h	X	
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		

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 lines 11a and b below.) If this is a defined contribution pension plan, leave line 12 below..... Yes No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 0

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- Yes.
- No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- No. Other. Provide explanation _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? Yes No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

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 _____

If 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**

c 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**

e 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 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

c 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.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2019

**This Form is Open to Public
Inspection**

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>MERIDIAN PEDIATRIC DENTAL GROUP DEFINED BENEFIT PENSION PLAN & TRUST</u>		B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>MERIDIAN PEDIATRIC DENTAL GROUP, LLC</u>		D Employer Identification Number (EIN) <u>45-5149070</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2019</u>			
2 Assets:	a Market value	2a	<u>2559531</u>
	b Actuarial value	2b	<u>2559531</u>
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
	a For retired participants and beneficiaries receiving payment	<u>0</u>	<u>0</u>
	b For terminated vested participants	<u>1</u>	<u>344</u>
	c For active participants	<u>11</u>	<u>2271487</u>
d Total	<u>12</u>	<u>2271831</u>	<u>2271831</u>
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5 Effective interest rate	5	<u>5.61 %</u>	
6 Target normal cost	6	<u>83768</u>	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	Signature of actuary	<u>09/22/2020</u>
	<u>DOUGLAS S. LANE</u>	Date
Type or print name of actuary		Most recent enrollment number
<u>NEWPORT GROUP ACTUARIAL SERVICES</u>		<u>515-453-8589</u>
Firm name		Telephone number (including area code)
<u>1075 JORDAN CREEK PARKWAY SUITE 270 WEST DES MOINES, IA 50266</u>		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

**Schedule SB (Form 5500) 2019
v. 190130**

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	68286
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	0	68286
10	Interest on line 9 using prior year's actual return of <u>-6.33</u> %	0	-4323
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		102083
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.82</u> %		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c	Total available at beginning of current plan year to add to prefunding balance		102083
d	Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	63963

Part III Funding Percentages			
14	Funding target attainment percentage	14	109.69 %
15	Adjusted funding target attainment percentage	15	114.48 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	101.39 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls		18 Contributions made to the plan for the plan year by employer(s) and employees:			
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
09/14/2019	10975		09/04/2020	20500	
03/06/2020	39414		09/17/2020	2111	
04/07/2020	13000				
06/03/2020	13000				
07/19/2020	20500				
08/07/2020	20500				
Totals ▶			18(b)	140000	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	137224

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? Yes No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? Yes No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: 3.74 %	2nd segment: 5.35 %	3rd segment: 6.11 %	<input type="checkbox"/> N/A, full yield curve used
------------------------	------------------------	------------------------	-----------------------------------------------------

b Applicable month (enter code) **21b** 2

22 Weighted average retirement age **22** 63

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment..... Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years.....	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29).....	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6).....	31a	83768
b Excess assets, if applicable, but not greater than line 31a	31b	83768

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment.....	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount..... **33**

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... **34** 0

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0
36 Additional cash requirement (line 34 minus line 35)			0
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)			137224
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)			137224
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances			0
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)			0
40 Unpaid minimum required contributions for all years.....			0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
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Short Form Annual Return/Report of Small Employee Benefit Plan

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

OMB Nos. 1210-0110
1210-0089

2019

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Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A This return/report is for: 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.)
 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: Form 5558 automatic extension DFVC program
 special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan Meridian Pediatric Dental Group Defined Benefit Pension Plan & Trust		1b Three-digit plan number (PN) ▶ 002
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) Meridian Pediatric Dental Group, LLC 1922 23rd Avenue Meridian MS 39301		1c Effective date of plan 01/01/2008
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		2b Employer Identification Number (EIN) 45-5149070
		2c Sponsor's telephone number (601) 482-8986
		2d Business code (see instructions) 621210
		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		4b EIN
		4d PN
5a Total number of participants at the beginning of the plan year	5a	12
b Total number of participants at the end of the plan year	5b	12
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c	
d(1) Total number of active participants at the beginning of the plan year	5d(1)	12
d(2) Total number of active participants at the end of the plan year	5d(2)	11
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	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	<i>Dr. J. Britt McCarty</i> Signature of plan administrator	3/6/2020 Date	J. Britt McCarty, D.M.D. Enter name of individual signing as plan administrator
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 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.) 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.)

Part III Financial Information			
7		(a) Beginning of Year	(b) End of Year
7	Plan Assets and Liabilities		
a	Total plan assets	7a 2,272,846	2,699,726
b	Total plan liabilities	7b 0	0
c	Net plan assets (subtract line 7b from line 7a)	7c 2,272,846	2,699,726
8		(a) Amount	(b) Total
a	Contributions received or receivable from:		
(1)	Employers	8a(1) 140,000	
(2)	Participants	8a(2) 0	
(3)	Others (including rollovers)	8a(3) 0	
b	Other income (loss)	8b 302,136	
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	442,136
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d 0	
e	Certain deemed and/or corrective distributions (see instructions) ...	8e 0	
f	Administrative service providers (salaries, fees, commissions)	8f 15,256	
g	Other expenses	8g 0	
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	15,256
i	Net income (loss) (subtract line 8h from line 8c)	8i	426,880
j	Transfers to (from) the plan (see instructions)	8j 0	

Part IV Plan Characteristics	
9a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1B 3H
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		Yes	No	Amount
a	During the plan year: 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	
c	Was the plan covered by a fidelity bond?	10c	X	500,000
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	X	
e	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	X	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	X	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h	X	
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		

**SCHEDULE SB
(Form 5500)**

**Single-Employer Defined Benefit Plan
Actuarial Information**

OMB No. 1210-0110

2019

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

This Form is Open to Public Inspection

▶ **File as an attachment to Form 5500 or 5500-SF.**

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

▶ **Round off amounts to nearest dollar.**

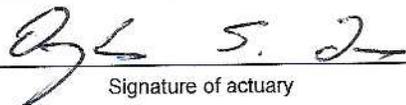
▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan Meridian Pediatric Dental Group Defined Benefit Pension Plan & Trust		B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Meridian Pediatric Dental Group, LLC		D Employer Identification Number (EIN) 45-5149070	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information			
1 Enter the valuation date:	Month <u>12</u> Day <u>31</u> Year <u>2019</u>		
2 Assets:			
a Market value		2a	2,559,531
b Actuarial value		2b	2,559,531
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	0	0	0
b For terminated vested participants	1	344	344
c For active participants	11	2,271,487	2,271,487
d Total	12	2,271,831	2,271,831
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor		4b	
5 Effective interest rate		5	5.61%
6 Target normal cost		6	83,768

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		<u>9/22/20</u>
	Signature of actuary	Date
Douglas S. Lane		20-04376
	Type or print name of actuary	Most recent enrollment number
Newport Group Actuarial Services		(515) 453-8589
	Firm name	Telephone number (including area code)
1075 Jordan Creek Parkway		
Suite 270		
West Des Moines IA 50266		
	Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

**Schedule SB (Form 5500) 2019
v. 190130**

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	68,286
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	0	68,286
10	Interest on line 9 using prior year's actual return of <u>-6.33%</u>	0	-4323
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		102083
	b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.82%</u>		0
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
	c Total available at beginning of current plan year to add to prefunding balance		102083
	d Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	63963

Part III Funding Percentages			
14	Funding target attainment percentage	14	109.69%
15	Adjusted funding target attainment percentage	15	114.48%
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	101.39%
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls							
18 Contributions made to the plan for the plan year by employer(s) and employees:							
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
09/14/2019	10,975		09/04/2020	20,500			
03/06/2020	39,414		09/17/2020	2,111			
04/07/2020	13,000						
06/03/2020	13,000						
07/19/2020	20,500						
08/07/2020	20,500						
Totals ▶			18(b)	140,000	18(c)	0	

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:			
a	Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b	Contributions made to avoid restrictions adjusted to valuation date	19b	0
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	137,224
20 Quarterly contributions and liquidity shortfalls:			
a	Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
b	If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c	If line 20a is "Yes," see instructions and complete the following table as applicable:		

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: 3.74 %	2nd segment: 5.35 %	3rd segment: 6.11 %
------------------------	------------------------	------------------------

N/A, full yield curve used

b Applicable month (enter code) **21b** 2

22 Weighted average retirement age **22** 63

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28** 0

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6) **31a** 83,768

b Excess assets, if applicable, but not greater than line 31a **31b** 83,768

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33**

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) **34** 0

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0
36 Additional cash requirement (line 34 minus line 35)			0
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)			137,224

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36) **38a** 137,224

b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b** 0

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0

40 Unpaid minimum required contributions for all years **40** 0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

Attachment to 2019 Form 5500
Schedule SB, line 22 - Description of Weighted Average Retirement Age

Plan Name Meridian Pediatric Dental Group Defined Benefit Pension Plan & Trust **EIN:** 45-5149070
Plan Sponsor's Name Meridian Pediatric Dental Group, LLC **PN:** 002

The weighted average retirement age is equal to the normal retirement age of 63.

List the rate of retirement at each age and describe the methodology used to compute the weighted average retirement age, including a description of the weight applied at each potential retirement age.

Schedule SB, Part V - Statement of Actuarial Assumptions

Target Assumptions:

Male Nonannuitant: 2019 Nonannuitant Male
 Female Nonannuitant: 2019 Nonannuitant Female
 Male Annuitant: 2019 Annuitant Male
 Female Annuitant: 2019 Annuitant Female
 Applicable months from valuation month: 2
 Probability of lump sum: 100.00%
 Use pre-retirement mortality: No

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Segment rates:	2.79	3.90	4.35
High Quality Bond rates:	N/A	N/A	N/A
Final rates:	3.74	5.35	6.11
Override:	0.00	0.00	0.00

Salary Scale

Male: 0.00%
 Female: 0.00%

Withdrawal

Male: N/A
 Female: N/A

Withdrawal-Select

Male: N/A
 Female: N/A

Early Retirement Rates

Male: N/A
 Female: N/A

Subsidized Early Retirement Rates

Male: N/A
 Female: N/A

Options:

Use optional combined mortality table for small plans: Yes
 Use discount rate transition: No
 Lump sums use proposed regulations: Yes

Actuarial Equivalent Floor

Stability period: plan year
 Lookback months: 2
 Nonannuitant: N/A
 Annuitant: 2019 Applicable

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Current:	3.43	4.46	4.88
Override:	2.04	3.09	3.68

Late Retirement Rates

Male: N/A
 Female: N/A

Marriage Probability

Male: 0.00%
 Female: 0.00%
 Expense loading: 0.00%

Setback

0

Disability Rates

Male: N/A
 Female: N/A

Mortality

Male: N/A
 Female: N/A

Setback

0

0

Name of Plan: Meridian Pediatric Dental Group DB I
 Plan Sponsor's EIN: 45-5149070
 Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Eligibility Requirements

Age (yrs) : 21
 Age (months) : 0
 Wait (months) : 12
 Two year eligibility : No

Service/Participation Requirements

Definition of years: Hours worked
 Continuing hours: 1,000
 Excluded classes: Salaried employee
 Other

Earnings

Total compensation excluding : 415 prior to participation

<u>Retirement</u>	<u>Normal</u>	<u>Early</u>	<u>Subsidized Early</u>	<u>Disability</u>	<u>Death</u>
Age:	63				
Service:	0				
Participation:	10				
Defined:	Plan year start nearest				

Benefit Reduction / Mortality table & setback

Male:	Actuarial Equivalence	Actuarial Equivalence	N/A	0
Female:	Actuarial Equivalence	Actuarial Equivalence	N/A	0
Rates - Male:	N/A	N/A	N/A	
Rates - Female:	N/A	N/A	N/A	

Use Social Security Retirement Age:	No	REACT Benefits Percentage:	50.00%
Vesting Schedule:	2/20	Pre-retirement death benefit	
Vesting Definition:	Hours Worked	Percentage of accrued benefit:	100.00%
		Death Benefit Payment method:	PVAB

	<u>Annuity</u>	<u>Percent</u>	<u>Years</u>
Normal:	Life only	0.00%	0
QJSA:	Joint and contingent	50.00%	0

Significant Changes in Plan Provisions Since Last Valuation

Name of Plan: Meridian Pediatric Dental Group DB PP&T
 Plan Sponsor's EIN: 45-5149070
 Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Benefits

Pension Formula:	Benefit formula		
Type of Formula:	Unit benefit non-integrated		
Effective Date:	01/01/2019		
Unit type:	Percent		
Unit based on:	Accrual		
Maximum total percent:	0.00%		
Tiers based on:	None		
First tier:	0.50%	for 1st	None
Second tier:	None	for next	None
Third tier:	None	for remaining yrs	
Maximum credit:			
Past years:	12		
Future years:	99		
Total years:	15		

Averaging

Projection method:	Current Compensation	Apply exclusion to accrued benefit:	No
Based on:	Final Average	Annualize short compensation years:	No
Highest:	3	Annualize short plan years:	No
In the last:	99	Include compensations based	
Excluding:	0	on years of:	Accrual

Accrual

Frozen:	No	Fractions based on:	N/A
Definition of years:	Hours worked		
Accrual credit:	<u>Continuing</u>	<u>Died</u>	<u>Disabled</u>
	100	100	100
		<u>Retired</u>	<u>Terminated</u>
		100	100
			Precision: N/A
			Limit current credit
			to: N/A
Years based on:	Participation	Cap/floor years:	10
Maximum past accrual years:	0.0000	Cap or floor:	Cap
Method:	Unit accrual	Accrual % per year:	0.00%
		Apply 415 before accrual:	No

Name of Plan: Meridian Pediatric Dental Group DB PP&T
Plan Sponsor's EIN: 45-5149070
Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Benefits

Pension Formula: SH/Pres of McCarty P.A.
Type of Formula: Unit benefit non-integrated
Effective Date: 01/01/2019

Unit type: Dollar
Unit based on: Participation
Maximum total percent:
Tiers based on: None
First tier: \$400.00 **for 1st** None
Second tier: None **for next** None
Third tier: None **for remaining yrs**

Maximum credit:
Past years: 12
Future years: 99
Total years: 15

Averaging

Projection method: Current Compensation **Apply exclusion to accrued benefit:** No
Based on: Final Average **Annualize short compensation years:** No
Highest: 3 **Annualize short plan years:** No
In the last: 99 **Include compensations based**
Excluding: 0 **on years of:** Participation

Accrual

Frozen: No
Definition of years: Hours worked **Fractions based on:** N/A

Accrual credit: Continuing Died Disabled Retired Terminated **Precision:** N/A
1000 1000 1000 1000 1000 **Limit current credit to:** N/A

Years based on: Participation **Cap/floor years:** 0
Maximum past accrual years: 0.0000 **Cap or floor:** Floor
Method: Unit accrual **Accrual % per year:** 0.00%
Apply 415 before accrual: No

Frozen Benefits

Fresh Start Date: 12/31/2018 **Fresh start approach** No wear away
Apply increase to frozen compensation: No **Reduce years and/or caps** Yes
Selected Formula: N/A **by frozen years:**

Name of Plan: Meridian Pediatric Dental Group DB PP&T
Plan Sponsor's EIN: 45-5149070
Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Benefits

Pension Formula: Other HCE
Type of Formula: Unit benefit non-integrated
Effective Date: 01/01/2019

Unit type: Dollar
Unit based on: Participation
Maximum total percent:
Tiers based on: None
First tier: \$1.00 **for 1st** None
Second tier: None **for next** None
Third tier: None **for remaining yrs**

Maximum credit:
Past years: 12
Future years: 99
Total years: 15

Averaging

Projection method: Current Compensation **Apply exclusion to accrued benefit:** No
Based on: Final Average **Annualize short compensation years:** No
Highest: 3 **Annualize short plan years:** No
In the last: 99 **Include compensations based**
Excluding: 0 **on years of:** Participation

Accrual

Frozen: No
Definition of years: Hours worked **Fractions based on:** N/A

Accrual credit: Continuing Died Disabled Retired Terminated **Precision:** N/A
1000 1000 1000 1000 1000 **Limit current credit**
to: N/A

Years based on: Participation **Cap/floor years:** 0
Maximum past accrual years: 0.0000 **Cap or floor:** Floor
Method: Unit accrual **Accrual % per year:** 0.00%
Apply 415 before accrual: No

Name of Plan: Meridian Pediatric Dental Group DB PP&T
Plan Sponsor's EIN: 45-5149070
Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Benefits

Pension Formula: Shelley W Ellis DMD PC
Type of Formula: Unit benefit non-integrated
Effective Date: 01/01/2014

Unit type: Dollar
Unit based on: Participation
Maximum total percent:
Tiers based on: None
First tier: \$600.00 **for 1st** None
Second tier: None **for next** None
Third tier: None **for remaining yrs**

Maximum credit:
Past years: 6
Future years: 99
Total years: 9

Averaging

Projection method: Current Compensation **Apply exclusion to accrued benefit:** No
Based on: Final Average **Annualize short compensation years:** No
Highest: 3 **Annualize short plan years:** No
In the last: 99 **Include compensations based**
Excluding: 0 **on years of:** Participation

Accrual

Frozen: No
Definition of years: Hours worked **Fractions based on:** N/A

Accrual credit: Continuing Died Disabled Retired Terminated **Precision:** N/A
1000 1000 1000 1000 1000 **Limit current credit**
to: N/A

Years based on: Participation **Cap/floor years:** 0
Maximum past accrual years: 0.0000 **Cap or floor:** Floor
Method: Unit accrual **Accrual % per year:** 0.00%
Apply 415 before accrual: No

Name of Plan: Meridian Pediatric Dental Group DB PP&T
Plan Sponsor's EIN: 45-5149070
Plan Number: 002

Schedule SB, Part V - Summary of Plan Provisions

Name of Plan: Meridian Pediatric Dental Group DB PP&T
Plan Sponsor's EIN: 45-5149070
Plan Number: 002

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2019

**This Form is Open to Public
Inspection**

For calendar plan year 2019 or fiscal plan year beginning _____ and ending _____

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan	B Three-digit plan number (PN) ▶	
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF	D Employer Identification Number (EIN)	
E Type of plan: <input type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1 Enter the valuation date: Month _____ Day _____ Year _____			
2 Assets:			
a Market value	2a		
b Actuarial value	2b		
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment			
b For terminated vested participants			
c For active participants			
d Total			
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5 Effective interest rate	5	%	
6 Target normal cost	6		

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		
	Signature of actuary	Date
	Type or print name of actuary	Most recent enrollment number
	Firm name	Telephone number (including area code)
	Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

**Schedule SB (Form 5500) 2019
v. 190130**

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)		
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)		
9	Amount remaining (line 7 minus line 8)		
10	Interest on line 9 using prior year's actual return of _____%		
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		
	b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of _____%		
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		
	c Total available at beginning of current plan year to add to prefunding balance		
	d Portion of (c) to be added to prefunding balance		
12	Other reductions in balances due to elections or deemed elections		
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)		

Part III Funding Percentages			
14	Funding target attainment percentage	14	%
15	Adjusted funding target attainment percentage	15	%
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	%
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
Totals ▶			18(b)		18(c)

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	
b Contributions made to avoid restrictions adjusted to valuation date	19b	
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? Yes No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? Yes No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: %	2nd segment: %	3rd segment: %	<input type="checkbox"/> N/A, full yield curve used
-------------------	-------------------	-------------------	-----------------------------------------------------

b Applicable month (enter code) **21b**

22 Weighted average retirement age **22**

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment..... Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28**

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... **29**

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30**

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6)..... **31a**

b Excess assets, if applicable, but not greater than line 31a **31b**

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment		
b Waiver amortization installment		

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount..... **33**

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... **34**

	Carryover balance	Prefunding balance	
35 Balances elected for use to offset funding requirement			

36 Additional cash requirement (line 34 minus line 35) **36**

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37**

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36) **38a**

b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b**

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39**

40 Unpaid minimum required contributions for all years **40**

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

Attachment to 2019 Form 5500
Schedule SB, line 22 - Description of Weighted Average Retirement Age

Plan Name	<u>Meridian Pediatric Dental Group Defined Benefit Pension Plan & Trust</u>	EIN:	<u>45-5149070</u>
Plan Sponsor's Name	<u>Meridian Pediatric Dental Group, LLC</u>	PN:	<u>002</u>

The weighted average retirement age is equal to the normal retirement age of 63 .

List the rate of retirement at each age and describe the methodology used to compute the weighted average retirement age, including a description of the weight applied at each potential retirement age.