

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

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning 09/01/2016 and ending 08/31/2017

- 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>FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, PA DEFINED BENEFIT PLAN</u>		1b Three-digit plan number (PN) ▶ <u>002</u>
		1c Effective date of plan <u>09/01/2002</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>FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, PA</u> <u>2428 JENKS AVENUE</u> <u>PANAMA CITY, FL 32405</u>		2b Employer Identification Number (EIN) <u>59-3756529</u>
		2c Sponsor's telephone number <u>850-763-0346</u>
		2d Business code (see instructions) <u>621111</u>
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		3b Administrator's EIN
		3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.		4b EIN
a Sponsor's name		4c PN
5a Total number of participants at the beginning of the plan year	5a	<u>4</u>
b Total number of participants at the end of the plan year	5b	<u>4</u>
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c	<u>0</u>
d(1) Total number of active participants at the beginning of the plan year	5d(1)	<u>3</u>
d(2) Total number of active participants at the end of the plan year	5d(2)	<u>3</u>
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	<u>0</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	<u>Filed with authorized/valid electronic signature.</u>	<u>06/13/2018</u>	<u>JAMES M. TALKINGTON, M.D.</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

- 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

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1987378	2259820
b Total plan liabilities.....	7b	0	0
c Net plan assets (subtract line 7b from line 7a).....	7c	1987378	2259820
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	105000	
(2) Participants.....	8a(2)	0	
(3) Others (including rollovers).....	8a(3)	0	
b Other income (loss).....	8b	196227	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	8c		301227
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	28785	
g Other expenses.....	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		28785
i Net income (loss) (subtract line 8h from line 8c).....	8i		272442
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: 1A 11 3D
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	N/A	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)		X		0
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.).....		X		0
c	Was the plan covered by a fidelity bond?	X			240000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		0
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.).....		X		0
f	Has the plan failed to provide any benefit when due under the plan?		X		0
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)		X		0
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				
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.....				

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)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a 0
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If "Yes," enter the amount of any plan assets that reverted to the employer this year		
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)

Part VIII Trust Information

14a Name of trust	14b Trust's EIN
14c Name of trustee or custodian	14d Trustee's or custodian's telephone number

Part IX IRS Compliance Questions

15a Is the plan a 401(k) plan? If "No," skip b.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
15b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:	<input type="checkbox"/> Design-based safe harbor <input type="checkbox"/> "Prior year" ADP test <input type="checkbox"/> "Current year" ADP test <input type="checkbox"/> N/A
16a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	<input type="checkbox"/> Ratio percentage test <input type="checkbox"/> Average benefit test <input type="checkbox"/> N/A
16b Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17a If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter ____/____/____ and the serial number _____.	
17b If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter ____/____/____.	
18 Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19 Was any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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

2016

**This Form is Open to Public
Inspection**

For calendar plan year 2016 or fiscal plan year beginning 09/01/2016 and ending 08/31/2017

▶ **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>FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, PA DEFINED BENEFIT PLAN</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>FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, PA</u>		D Employer Identification Number (EIN) <u>59-3756529</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>09</u> Day <u>01</u> Year <u>2016</u>			
2 Assets:	a Market value	2a	<u>1982716</u>
	b Actuarial value	2b	<u>1982716</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>736</u>
	c For active participants	<u>3</u>	<u>2208158</u>
d Total	<u>4</u>	<u>2208894</u>	<u>2208894</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>5.99%</u>	
6 Target normal cost	6	<u>0</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>06/08/2018</u>
	Type or print name of actuary	Date
	Firm name	Most recent enrollment number
	Address of the firm	Telephone number (including area code)

GLEN ARCHINAL, EA, MSPA, MAAA
17-02853
CBIZ RETIREMENT PLAN SERVICES
330-644-2044
13680 CLEVELAND AVE NW
UNIONTOWN, OH 44685

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) 2016
v. 160205**

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	12291
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	12291
10	Interest on line 9 using prior year's actual return of <u>-0.44%</u>	0	-54
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		36246
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>6.17%</u>		2236
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		38482
d	Portion of (c) to be added to prefunding balance		38482
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	50719

Part III Funding Percentages			
14	Funding target attainment percentage.....	14	87.46%
15	Adjusted funding target attainment percentage	15	87.46%
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	76.97%
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		
06/12/2017	20000	0					
07/17/2017	30000	0					
10/26/2017	25000	0					
05/08/2018	30000	0					
			Totals ▶	18(b)	105000	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	97299

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
0	0	0	0

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

21 Discount rate:

a Segment rates:	1st segment: 4.43%	2nd segment: 5.91%	3rd segment: 6.65%	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code) **21b** 0

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	0
b Excess assets, if applicable, but not greater than line 31a	31b	0

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	276897	83467
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	83467
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	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)	36	83467
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	97299

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

a Total (excess, if any, of line 37 over line 36)	38a	13832
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

42 Amount of acceleration adjustment	42	
43 Excess installment acceleration amount to be carried over to future plan years	43	

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST
Schedule SB, Part V - Statement of Actuarial Assumptions/Methods
Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN
Plan EIN: 59-3756529
Plan Number: 002

Normal Retirement Benefit

Actuarial Cost Method: PPA06 Funding Rules

IRC430 Funding Yield Curve Segmented Rates

First Segment:	4.43%
Second Segment:	5.91%
Third Segment:	6.65%

IRC404 Funding Yield Curve Segmented Rates

First Segment:	1.52%
Second Segment:	3.8%
Third Segment:	4.79%

PBGC Segmented Rates

First Segment:	1.39%
Second Segment:	3.27%
Third Segment:	4.18%

Pre-Retirement Valuation Assumptions

Mortality Table	NONE
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Retirement Valuation Assumptions

Mortality Table	2016 430(h)(3)(A)-Annuitants
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IRC417(e)(3) Interest Assumption

Segment Rate	same as Funding Yield Curve Segmented Rates
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IRC417(e)(3) Pre-retirement Mortality

Mortality Table	NONE
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IRC417(e)(3) Retirement Mortality

Mortality Table	2016 417(e)(3) Applicable Mortality Table
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Optional Forms Assumption

- 0% of participants will elect the Plan Normal Form
- 100% of participants will elect a Lump Sum (single payment)
- 0% of participants will elect a Single Life annuity with 5 years certain
- 0% of participants will elect a Single Life annuity with 10 years certain
- 0% of participants will elect a 50% Joint & Survivor annuity
- 0% of participants will elect a 100% Joint & Survivor annuity

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST
Schedule SB, Part V - Statement of Actuarial Assumptions/Methods
Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN
Plan EIN: 59-3756529
Plan Number: 002

Disability Benefit

Disability Benefit Liability not explicitly funded

Pre-Retirement Actuarial Equivalence Assumptions

Investment Earnings	6% Effective annual rate
Mortality Table	NONE

Retirement Actuarial Equivalence Assumptions

Investment Earnings	6% Effective annual rate
Mortality Table	1983 GAM DRAFT 50/50 BLEND M/F

Assumptions for IRC415 Maximum Benefit Actuarial Adjustments

Investment Earnings	5% Effective annual rate
Mortality Table	2016 417(e)(3) Applicable Mortality Table

Retirement Protection Act of 1994 Interest Rate for non-life annuities

Investment Earnings	5.5% Effective annual rate
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**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

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 09/01/2016 and ending 08/31/2017

▶ **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 Florida Sports Medicine & Orthopaedics PA Defined Benefit Plan	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Florida Sports Medicine & Orthopaedics Pa	D Employer Identification Number (EIN) 59-3756529	
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>09</u> Day <u>01</u> Year <u>2016</u>			
2 Assets:			
a Market value.....	2a	1,982,716	
b Actuarial value.....	2b	1,982,716	
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	736	736
c For active participants.....	3	2,208,158	2,208,158
d Total.....	4	2,208,894	2,208,894
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	5.99%	
6 Target normal cost.....	6	0	

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	GLEN ARCHINAL, EA, MSPA, MAAA <i>GA</i> _____ Signature of actuary	<i>06/08/2018</i> _____ Date
	GLEN ARCHINAL, EA, MSPA, MAAA _____ Type or print name of actuary	1702853 _____ Most recent enrollment number
	CBIZ RETIREMENT PLAN SERVICES _____ Firm name	330-644-2044 _____ Telephone number (including area code)
	13680 CLEVELAND AVE. NW _____ UNIONTOWN OH 44685 _____ 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

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

21 Discount rate:				
a Segment rates:	1st segment: 4.43 %	2nd segment: 5.91 %	3rd segment: 6.65 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code).....				21b 0
22 Weighted average retirement age				22 63
23 Mortality table(s) (see instructions)	<input type="checkbox"/> Prescribed - combined <input checked="" type="checkbox"/> Prescribed - separate <input type="checkbox"/> 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.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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	0	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment.....	276,897	83,467	
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	83,467	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....			0
36 Additional cash requirement (line 34 minus line 35).....	36	83,467	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	97,299	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	13,832	
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	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
b Eligible plan year(s) for which the election in line 41a was made	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST

Schedule SB, line 19 - Discounted Employer Contributions

Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN

Plan EIN: 59-3756529

Plan Number: 002

Date	Amount	Plan Year	Effective Rate of Interest	Discounted Amount	Penalty Rate of Interest	Additional Discounted Amount	Value As of Valuation Date
06/12/2017	20000.00	2016	5.99%	19115.00	10.99%	-414.23	18700.77
07/17/2017	30000.00	2016	5.99%	28513.00	10.99%	-307.00	28206.00
10/26/2017	25000.00	2016	5.99%	23381.00	10.99%	-188.89	23192.11
05/08/2018	30000.00	2016	5.99%	27203.00	10.99%	-3.18	27199.82
Total for Minimum Required Contribution	105000.00			98212.00		-913.30	97298.70

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST

Schedule SB, line 22 - Description of Weighted Average Retirement Age

Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN

Plan EIN: 59-3756529

Plan Number: 002

The weighted average retirement age of 63 is the average of the assumed retirement ages for all active participants as of the valuation date rounded to the nearest whole age. For an active late retiree, the assumed retirement age may be later than the Plan's normal retirement age. Each participant's rate of retirement is assumed to be 100% as of the participant's assumed retirement age.

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST

Schedule SB, Part V - Summary of Plan Provisions

Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN

Plan EIN: 59-3756529

Plan Number: 002

Plan Effective Date	September 1, 2002
Plan Anniversary Date	September 1, 2016
Participation Eligibility	Minimum age: 20.5 and Minimum months of service: 6
Plan Entry Date	Anniversary coincident with or following the satisfaction of the requirements
Normal Retirement Date	First day of the month coincident with or following age 62
Normal Form of Benefit	Single Life Annuity (Qualified Joint and Survivor annuity is the required standard option)
Retirement Benefit Optional Forms	Lump Sum (single payment) Single Life Annuity with 5 years certain Single Life Annuity with 10 years certain 50% Monthly Joint and Survivor Annuity 100% Monthly Joint and Survivor Annuity
Normal Retirement Benefit	Benefit Formula: 7.14% per year of future service times compensation Maximum total years of service: 14 Maximum years of past service: 0 Past service is prior to the effective date IRC415 maximum annual benefit: \$215,000 Actuarially adjusted under IRC415(b) for benefit commencement age and benefit form Plan maximum annual benefit: \$176,715 Benefit limited to 100% of compensation Minimum benefit: 2% of compensation per year of topheavy plan service up to 10 (actuarially adjusted for benefit form)
Compensation Definition	Highest consecutive 3 year average salary over all service Annual salary up to \$265,000 considered
Pre-Retirement Death Benefit	Lump sum payable on death of participant
Benefit Amount	100% present value of accrued benefit
Vested Retirement Benefit	Vesting Schedule: 20% a year after 2 years (100% after 6 years) Exclude service before effective date Computation Period: Years Beginning 9/1 Based on Hours Worked Records

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST

Schedule SB, Part V - Summary of Plan Provisions

Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN

Plan EIN: 59-3756529

Plan Number: 002

Accrued Retirement Benefit

Units accrued to date

Maximum number of years of past credited benefit accrual service is 0

Disability Benefit

Lump sum payable upon disability

Benefit Amount: 1 times the current monthly accrued retirement benefit

FLORIDA SPORTS MEDICINE AND ORTHOPAEDICS, P.A DEFINED BENEFIT PLAN AND TRUST

Schedule SB, line 32 - Schedule of Amortization Bases

Plan Name: FLORIDA SPORTS MEDICINE & ORTHOPAEDICS DEFINED BENEFIT PLAN

Plan EIN: 59-3756529

Plan Number: 002

Type of Base	Present Value	Date Established	Years Remaining	Amount of Installment
Shortfall Base	82,216	09/01/2011	2	41,999
Shortfall Base	-77,026	09/01/2012	3	-26,796
Shortfall Base	181,284	09/01/2013	4	48,309
Shortfall Base	-29,136	09/01/2014	5	-6,343
Shortfall Base	298,721	09/01/2015	6	55,900
Shortfall Base	-179,162	09/01/2016	7	-29,602
Total	276,898			83,467