

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 2017 This Form is Open to Public Inspection
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Part I Annual Report Identification Information		
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>		
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
	<input type="checkbox"/> a one-participant plan	<input type="checkbox"/> a foreign plan
B This return/report is	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension
	<input type="checkbox"/> special extension (enter description)	<input type="checkbox"/> DFVC program

Part II Basic Plan Information —enter all requested information		
1a Name of plan <u>PREMIER WALK-IN CLINIC PENSION PLAN</u>	1b Three-digit plan number (PN) ►	<u>001</u>
	1c Effective date of plan	<u>01/01/2007</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>PREMIER WALK-IN CLINIC & PRIMARY CARE, L. L. C.</u> <u>5408 BURNT HICKORY DRIVE</u> <u>VALRICO, FL 33596</u>	2b Employer Identification Number (EIN) <u>20-1553372</u>	
	2c Sponsor's telephone number <u>863-644-3400</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 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>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	
d(1) Total number of active participants at the beginning of the plan year.....	5d(1)	<u>4</u>
d(2) Total number of active participants at the end of the plan year	5d(2)	<u>4</u>
e Number of participants who 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	Filed with authorized/valid electronic signature.	10/02/2018	NARINDER BRAR
	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

- 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 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1450415	1601780
b Total plan liabilities	7b	0	
c Net plan assets (subtract line 7b from line 7a)	7c	1450415	1601780
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	35000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	125764	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		160764
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	9399	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		9399
i Net income (loss) (subtract line 8h from line 8c)	8i		151365
j Transfers to (from) the plan (see instructions)	8j		

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 3B 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

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (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		140000
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			
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 line 11a below) ☒ Yes ☐ 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? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)

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 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

▶ **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>PREMIER WALK-IN CLINIC PENSION PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>PREMIER WALK-IN CLINIC & PRIMARY CARE, L. L. C.</u>	D Employer Identification Number (EIN) <u>20-1553372</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
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Part I Basic Information

1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2017</u>			
2 Assets:			
a Market value	2a	<u>1566780</u>	
b Actuarial value	2b	<u>1514823</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>	<u>0</u>
b For terminated vested participants	<u>0</u>	<u>0</u>	<u>0</u>
c For active participants	<u>4</u>	<u>1663715</u>	<u>1663715</u>
d Total	<u>4</u>	<u>1663715</u>	<u>1663715</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>5.72 %</u>	
6 Target normal cost	6	<u>3343</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			<u>09/28/2018</u>
Signature of actuary		Date	
<u>STEVEN D. OLSON</u>		<u>17-04221</u>	
Type or print name of actuary		Most recent enrollment number	
<u>ASCENSUS, LLC</u>		<u>813-490-1223</u>	
Firm name		Telephone number (including area code)	
<u>2203 N. LOIS AVE. SUITE 1150 TAMPA, FL 33607</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 ☐

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	0
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	0
10 Interest on line 9 using prior year's actual return of <u>6.82</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		303
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>5.95</u> %		18
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		321
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	0

Part III Funding Percentages

14 Funding target attainment percentage	14	91.05%
15 Adjusted funding target attainment percentage	15	92.88%
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	91.09%
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
09/04/2018	35000				
Totals ▶			18(b)	35000	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	32567

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: 4.16 %	2nd segment: 5.72 %	3rd segment: 6.48 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)				21b 3
22 Weighted average retirement age.....				22 70
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input 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	3343	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance		Installment
a Net shortfall amortization installment.....	148892		27248
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	30591	
	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	30591	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	32567	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	1976	
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	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		

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 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

▶ **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 Premier Walk-In Clinic Pension Plan	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Premier Walk-In Clinic & Primary Care, L. L. C.	D Employer Identification Number (EIN) 20-1553372
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>2017</u>			
2 Assets:			
a Market value.....	2a	1,566,780	
b Actuarial value	2b	1,514,823	
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	0	0	0
c For active participants	4	1,663,715	1,663,715
d Total	4	1,663,715	1,663,715
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	5.72 %	
6 Target normal cost	6	3,343	

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		9/28/18
Signature of actuary		Date
Steven D. Olson		17-04221
Type or print name of actuary		Most recent enrollment number
Ascensus, LLC		(813) 490-1223
Firm name		Telephone number (including area code)
2203 N. Lois Ave. Suite 1150 Tampa		
Address of the firm		
FL 33607		

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 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	0
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	0
10 Interest on line 9 using prior year's actual return of <u>6.82</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		303
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>5.95</u> %		18
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		321
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	0

Part III Funding Percentages

14 Funding target attainment percentage	14	91.05%
15 Adjusted funding target attainment percentage	15	92.88%
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	91.09%
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
09/04/2018	35,000				
Totals ►			18(b)	35,000	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	32,567

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: 4.16 %	2nd segment: 5.72 %	3rd segment: 6.48 %	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code)..... **21b** 3**22** Weighted average retirement age **22** 70**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** 3,343**b** Excess assets, if applicable, but not greater than line 31a **31b**

Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment.....	148,892	27,248
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** 30,591

	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** 30,591**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)..... **37** 32,567**38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36) **38a** 1,976**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** 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**

ATTACHMENT TO SCHEDULE SB (form 5500) Line 19

Name of Plan Sponsor: Premier Walk-In Clinic & Primary Care, L.L.C.
 Name of Plan: Premier Walk-In Clinic Pension Plan
 Plan Sponsors EIN: 20-1553372
 Plan Number: 001
 Reference : Line 19
 Valuation Date: 12/31/2017
 Effective Interest Rate: 5.72%

Quarterly Contribution Requirement: \$6,484
 Effective Interest Rate + 5.0%: 10.72%

Quarterly Due Date	Actual Contribution Date	Amount Due	Days Late	Late Payment Penalty	Days to 12/31	Interest	Total for Line 19c	
04/15/2017	09/04/2018	6,484	507	388	-247	-240	5,856	
07/15/2017	09/04/2018	6,484	416	320	-247	-240	5,924	
10/15/2017	09/04/2018	6,484	324	250	-247	-240	5,994	
01/15/2018	09/04/2018	6,484	232	180	-247	-240	6,064	
Total Quarterlies		25,936		1,138		-960	23,838	
		Other Contribution Dates	Contribution Amount			Days to 12/31	Interest	Total for Line 19c
		09/04/2018	9,064			-247	-335	8,729
Total Other		9,064					-335	8,729
Total		35,000		1,138		-1,295	32,567	

Method = (contribution x rate) ^ (days/365)
 Rate is valuation effective investment return rate

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

Pension Benefit Guaranty Corporation

**Short Form Annual Return/Report of Small Employee
Benefit Plan**This form is required to be filed under sections 104 and 4065 of the Employee Retirement
Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal
Revenue Code (the Code).▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**OMB Nos. 1210-0110
1210-0089**2017****This Form is Open to
Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

- 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 Premier Walk-In Clinic Pension Plan		1b Three-digit plan number (PN) ▶ 001	1c Effective date of plan 01/01/2007
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) Premier Walk-In Clinic & Primary Care, L. L. C. 5408 Burnt Hickory Drive Valrico FL 33596		2b Employer Identification Number (EIN) 20-1553372	2c Sponsor's telephone number (863) 644-3400
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		2d Business code (see instructions) 621111	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.		4b EIN	4d PN
a Sponsor's name			
c Plan Name			
5a Total number of participants at the beginning of the plan year	5a	4	
b Total number of participants at the end of the plan year	5b	4	
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)	4	
d(2) Total number of active participants at the end of the plan year	5d(2)	4	
e 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/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>Narinder S Brar, MPA</i>	<u>10/22/18</u>	Narinder Brar
	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

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

Form 5500-SF (2017)
v.170203

ATTACHMENT TO SCHEDULE SB (FORM 5500) Line 22

Name of Plan Sponsor: Premier Walk-In Clinic & Primary Care, LLC

Name of Plan: Premier Walk-In Clinic Pension Plan

Plan Sponsor's EIN: 20-1553372

Plan Number: 001

Reference: Line 22

All participants, except the owner, are assumed to retire at their Normal Retirement Age. The owner is assumed to retire at Age 70. If later, the assumed retirement age is one year from the valuation date.

Method of Weighted Average Retirement Age:

The sum of the product of the assumed retirement age for each participant and the present value of accrued benefits using plan rates divided by the sum of present value of accrued benefits.

ATTACHMENT TO SCHEDULE SB (form 5500) Line 32

Name of Plan Sponsor: Premier Walk-In Clinic & Primary Care, L.L.C.
 Name of Plan: Premier Walk-In Clinic Pension Plan
 Plan Sponsors EIN: 20-1553372
 Plan Number: 001
 Reference : Line 32
 Valuation Date: 12/31/2017

Type of Base	Effective Date	Interest Rate	Initial Amount	Initial Amort	Current Balance	Remaining Amortization	Payment
Shortfall	12/31/2015	4.43/5.91	6,763	7.00	5,193	5.00	1,125
Shortfall	12/31/2016	4.43/5.91	129,995	7.00	115,411	6.00	21,478
Shortfall	12/31/2017	4.43/5.91	28,288	7.00	28,288	7.00	4,645
Totals					148,892		27,248

Premier Walk-In Clinic & Primary Care, LLC
Premier Walk-In Clinic Pension Plan
Plan Sponsor's EIN: 20-1553372 Plan Number: 001
Schedule SB, Part V - SUMMARY OF PLAN PROVISIONS

EFFECTIVE DATE	01/01/2007
VALUATION DATE	12/31/2017
ELIGIBILITY	Minimum Age: 21 Minimum Service: 1 Year Entry 1/1 or 7/1 next following Excludes union employees and non-resident aliens
HOURS REQUIREMENT	Eligibility – 1,000 hours Credited Year of Service – 1,000 hours Vesting – 1,000 Hours
AVERAGE ANNUAL COMPENSATION	Average of annual compensation during 3 consecutive determination periods that produces the highest average during all plan years
NORMAL RETIREMENT	Age 65 or participant's fifth anniversary of joining the plan, if later
BENEFIT FORMULA	3% of Average Compensation per Credited Year of Service (up to 25) Years before effective date of plan are excluded for benefit accrual purposes
NORMAL FORM OF BENEFIT	Life Annuity
EARLY RETIREMENT	N/A. No Early Retirement provision is provided
VESTING SCHEDULE	6-year graded schedule Service prior to effective date of the plan is not counted for vesting purposes
ACTUARIAL EQUIVALENCE	Pre-retirement: 5.5% Post-retirement: 5.5% & 1994 GAR Unisex Table projected to 2002
DEATH BENEFIT	Excess of present value of participant's vested accrued benefit minus present value of QPSA benefit
DISABILITY BENEFIT	N/A. No Disability Benefit provision is provided
LATE RETIREMENT	The greater of the Normal Retirement benefit and Actuarial Equivalent benefit

Premier Walk-In Clinic & Primary Care, L.L.C.

Premier Walk-In Clinic Pension Plan

Plan Sponsor's EIN: 20-1553372 Plan Number: 001

Schedule SB, Part V - Statement of Actuarial Assumptions

Funding Method:

Cost Method: PPA Unit Credit

Asset Valuation: Fair Market Value

Target Assumptions:

Male Nonannuitant: 2017 Nonannuitant Male
Female Nonannuitant: 2017 Nonannuitant Female
Male Annuitant: 2017 Annuitant Male
Female Annuitant: 2017 Annuitant Female

Applicable months from valuation month: 3
Probability of lump sum: 0.00%
Use pre-retirement mortality: No

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Segment rates:	1.75	3.76	4.66
25 year average rates:	4.62	6.35	7.20
Final rates:	4.16	5.72	6.48
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: 1
Nonannuitant: N/A
Annuitant: 2017 Applicable

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Current:	2.04	4.03	4.82
Override:	0.00	0.00	0.00

Late Retirement Rates

Male: N/A
Female: N/A

Marriage Probability

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

Disability Rates

Male: N/A
Female: N/A

	<u>Mortality</u>	<u>Setback</u>
Male:	N/A	0
Female:	N/A	0