Form 5500-SF         Short Form Annual Return/Report of Small Em           Department of the Treasury         Benefit Plan					oyee	OMB Nos. 1210-0110 1210-0089			
	nal Revenue Service	This form is required to be filed			8(a) of the Internal This Form is 0				
	epartment of Labor enefits Security Administration	Income Security Act of 1974 (	ERISA), and sections 6 Revenue Code (the Co						
Pension Be	enefit Guaranty Corporation	Complete all entries in a	ccordance with the ins	structions to the Form 5	Public Inspection				
Part I		dentification Information							
For calenda	ar plan year 2017 or fis	cal plan year beginning 01/01/20	—		2/31/2017	the data because and a data because			
A This ret	turn/report is for:	a single-employer plan	list of participating e	pian (not multiemployer) ( employer information in ac		king this box must attach a vith the form instructions.)			
<b>B</b> This retu	urn/report is	a one-participant plan	a foreign plan						
		the first return/report	the final return/repor						
•		an amended return/report	an amended return/report a short plan year return/report (less than 12 months)						
C Check I	box if filing under:	× Form 5558	automatic extension	I	DFVC p	rogram			
		special extension (enter descri							
Part II		rmation—enter all requested info	ormation		41.				
1a Name	•				1b Thre	e-digit number			
BLUEGRAS	BLUEGRASS ORTHOPAEDICS 401(K) & PROFIT SHARING PLAN					► 001			
			1c Effect	tive date of plan 10/02/1992					
		ver, if for a single-employer plan)	Box)		2b Employer Identification Number				
City or	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) BLUEGRASS ORTHOPAEDICS & HAND CARE, PSC				(EIN) 47-5354567 <b>2c</b> Sponsor's telephone number				
BLUEGRAS	S OKTHOPAEDICS & I	HAND CARE, FOC			859-422-4569				
3480 YORKS	SHIRE MEDICAL PARK	<			2d Business code (see instructions)				
LEXINGTON					621399				
22 Dian a	dministrator's name an	d addraga V Cama og Dian Snan			<b>3b</b> Administrator's EIN				
Ja Plan a	dministrator's name and	d address 🗙 Same as Plan Spon	SOF.		SU Adm	Instrator's Ein			
					<b>3c</b> Administrator's telephone number				
		plan sponsor or the plan name ha sor's name, EIN, the plan name ar			4b EIN				
•	or's name	isor s hame, Lin, the plan hame a			<b>4d</b> PN				
C Plan N	lame								
5a Total	number of participants a	at the beginning of the plan year			5a	118			
		at the end of the plan year			5b	130			
		account balances as of the end of t		•	5c	130			
<b>d(1)</b> Tota	al number of active part	ticipants at the beginning of the pla	n year		5d(1)	88			
• •		ticipants at the end of the plan yea			5d(2)	94			
		terminated employment during the			5e	5			
Caution: A	penalty for the late o	or incomplete filing of this return	/report will be assesse	d unless reasonable ca					
SB or Sche		er penalties set forth in the instruct d signed by an enrolled actuary, as lete							
SIGN		valid electronic signature.	10/15/2018	DR. JASON HARROD	)				
HERE	Signature of plan ac		Date	Enter name of individ		as plan administrator			
SIGN									
HERE	Signature of employ	ver/plan sponsor	Date	Enter name of individ	ual signing	as employer or plan sponsor			
L	- signature et employ	,,							

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

Form 5500-SF (2017) v.170203

<ul> <li>6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)</li></ul>							
Pa	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			
а	Total plan assets	7a	8220054	10443038			
b	Total plan liabilities	7b					
С	Net plan assets (subtract line 7b from line 7a)	7c	8220054	10443038			
8 Income, Expenses, and Transfers for this Plan Year			(a) Amount	(b) Total			
а	Contributions received or receivable from:						

Pa	rt III Financial Information	-							
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End of Year		
а	Total plan assets	7a	822	20054			10443038		
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7c	822	20054			10443038		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t		(b) Total			
а	Contributions received or receivable from: (1) Employers	8a(1)	49	94981					
	(2) Participants	8a(2)		11640					
	(2) Others (including rollovers)	8a(3)		38577					
b	Other income (loss)	8b		42629					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					2387827		
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	ł	55570					
е	Certain deemed and/or corrective distributions (see instructions)	8e	:	20662					
f	Administrative service providers (salaries, fees, commissions)	8f	3	88611					
g	Other expenses	8g							
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					164843		
i	Net income (loss) (subtract line 8h from line 8c)	8i					2222984		
j	Transfers to (from) the plan (see instructions)	8j							
Pa	rt IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2E $2G$ 2J $2K$ 3D	feature co	odes from the List of Pl	an Cha	racteri	stic Co	des in the instructions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature coo	des from the List of Pla	n Chara	acterist	ic Coc	les in the instructions:		
Par	t V Compliance Questions								
10	During the plan year:				Yes	No	Amount		
a	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary l	Fiduciary Correction	10a		х			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		Х			
С	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 by fraud or dishonesty?	•		10d		х			
e	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	ne or all of	the benefits under	10e	x		62688		
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		Х			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g	Х		153662		
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)			10h		Х			
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i					

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Page 3- 1

Part	VI	Pension Funding Compliance					
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sch rm 5500) and line 11a below)	nedule	SB		Yes	s 🗙 No
11a	Ent	er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	. 11a				
12	ERI	his a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or sectic SA? "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	on 302	of		Yes	s 🗙 No
a		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, an nting the waiver		r the date	e of the le Yea		uling
lf y	you d	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.					
b	Ente	r the minimum required contribution for this plan year	12b				
С	Ente	r the amount contributed by the employer to the plan for this plan year	12c				
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a ative amount)	12d				
е	Will	the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No		N/A
Part '	VII	Plan Terminations and Transfers of Assets					
13a	Has	a resolution to terminate the plan been adopted in any plan year?		Ye	es X	No	
	lf "Y	es," enter the amount of any plan assets that reverted to the employer this year	13a				
b		re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the trol of the PBGC?	•		Yes	×I	No
С		luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s ch assets or liabilities were transferred. (See instructions.)	) to				
1	3c(1	) Name of plan(s): 13c(2	) EIN(s	5)	130	: <b>(3)</b> F	'N(s)

Form 5500-SF	Short Form Annual R	eturn/Report o Benefit Plan	of Small Employ	vee	OMB Nos. 1210-0110 1210-0089			
Department of the Treasury Internal Revenue Service	65 of the Employee Retir	ement	2017					
Department of Labor         Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).         This Form is Op Public Inspect           Pension Benefit Guaranty Corporation         > Complete all entries in accordance with the instructions to the Form 5500-SF.         This Form is Op Public Inspect								
Part I Annual Repo	rt Identification Information	dance with the firstru	citoris to the Form 5500	-51.				
	fiscal plan year beginning 01/01/2017		and ending 12/31/2	2017				
A This return/report is for:		and some present to be a set of the set of	n (not multiemployer) (File loyer information in acco		ing this box must attach a the form instructions.)			
<b>B</b> This return/report is		ne final return/report	report (less than 12 mont	ths)				
		Short plan your rotain.						
C Check box if filing under:	X Form 5558	automatic extension		DFVC pr	ogram			
	special extension (enter description	)						
Part II Basic Plan In	formation—enter all requested information	tion		-				
1a Name of plan BLUEGRASS ORTHOPAEDICS	S 401(K) & PROFIT SHARING PLAN		1	b Three plan r (PN)	number			
			1	c Effect	tive date of plan 2/1992			
Mailing address (include r	bloyer, if for a single-employer plan) bom, apt., suite no. and street, or P.O. Box	<)		2b Employer Identification Num (EIN) 47-5354567				
-	City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BLUEGRASS ORTHOPAEDICS & HAND CARE, PSC				2c Sponsor's telephone number (859) 422-4569			
3480 YORKSHIRE MEDICAL P	ARK			62139	ess code (see instructions) 99			
LEXINGTON, KY 40509 <b>3a</b> Plan administrator's name	and address X Same as Plan Sponsor.		3	<b>Bb</b> Admi	nistrator's EIN			
			3	3c Admi	nistrator's telephone number			
4 If the name and/or EIN of this plan, enter the plan s	the plan sponsor or the plan name has cha ponsor's name, EIN, the plan name and th	anged since the last re ne plan number from the	e last return/report.	4b EIN				
a Sponsor's name c Plan Name			4	4d PN				
5a Total number of participa	nts at the beginning of the plan year			5a	118			
	nts at the end of the plan year			5b	130			
c Number of participants w	ith account balances as of the end of the p	lan year (only defined	contribution plans	5c	130			
	participants at the beginning of the plan ye			5d(1)	88			
d(2) Total number of active	participants at the end of the plan year			5d(2)	94			
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested					5			
Caution: A penalty for the la	ate or incomplete filing of this return/rep d other penalties set forth in the instructions d and gigned by an enrolled actuary, as we	s I declare that I have	unless reasonable caus examined this return/report, sion of this return/report,	JIL IIICIUU	ing, il applicable, a concoule			
SIGN 10-15-18 Dr. Jason Harrod								
HEDE	an administrator	Date	Enter name of individua	al signing	as plan administrator			
SIGN					1			
HERE Signature of em	nployer/plan sponsor lotice, see the Instructions for Form 5500-SF.	Date	Enter name of individua	al signing	as employer or plan sponsor Form 5500-SF (2017 v.170203			

Form 5500-SF 2017

<ul><li>6a Were all of the plan's assets during the plan year invested in e</li><li>b Are you claiming a waiver of the annual examination and repo</li></ul>	eligible assets? (	(See instructions.)	counta	nt (IQF	?A)			
D Are you claiming a waiver of the annual examination and report under 29 CFR 2520.104-46? (See instructions on waiver eligit If you answered "No" to either line 6a or line 6b, the plan of	bility and condition	ons.)				X Yes No.		
<b>C</b> If the plan is a defined benefit plan, is it covered under the PBC	GC insurance pr	ogram (see ERISA sec	tion 40	21)?	🗌 Ye	es No Not determined		
If "Yes" is checked, enter the My PAA confirmation number fro	om the PBGC pr	emium filing for this pla	an year			(See instructions.)		
Part III Financial Information				_				
7 Plan Assets and Liabilities		(a) Beginning o				(b) End of Year		
a Total plan assets	7a	8	3220054	4		10443038		
b Total plan liabilities	7b							
C Net plan assets (subtract line 7b from line 7a)		8	3220054	4		10443038		
8 Income. Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total		
a Contributions received or receivable from:			10.000					
(1) Employers	8a(1)		49498					
(2) Participants	8a(2)		41164					
(3) Others (including rollovers)	8a(3)		3857	7				
b Other income (loss)			144262	9				
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)						2387827		
<ul> <li>d Benefits paid (including direct rollovers and insurance premiu to provide benefits)</li> </ul>	ms		5557					
e Certain deemed and/or corrective distributions (see instruction	ns) 8e	20662						
f Administrative service providers (salaries, fees, commissions	) 8f		8861	1				
g Other expenses								
h Total expenses (add lines 8d, 8e, 8f, and 8g)						164843		
Net income (loss) (subtract line 8h from line 8c)						2222984		
Transfers to (from) the plan (see instructions)								
-	0							
Part IV         Plan Characteristics           9a         If the plan provides pension benefits, enter the applicable pendices and the plan provides pension benefits, enter the applicable pendices and the plan provides pension benefits, enter the applicable pendices and the plan provides pension benefits, enter the applicable pendices and the plan provides pension benefits, enter the applicable pendices and the plan pendices and the pl	ension feature co	odes from the List of Pla	an Chai	racteris	stic Code	es in the instructions:		
b If the plan provides welfare benefits, enter the applicable we	Ifare feature coo	les from the List of Pla	n Chara	acterist	ic Codes	s 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 co descr bed in 29 CFR 2510.3-102? (See instructions and D Program)	OL's Voluntary H	-iduciary Correction	10a		×	(		
<ul> <li>b Were there any nonexempt transactions with any party-in-in reported on line 10a.)</li> </ul>	nterest? (Do not	include transactions	10b		×			
C Was the plan covered by a fidelity bond?			10c	X		5000		
<ul> <li>d Did the plan have a loss, whether or not reimbursed by the by fraud or dishonesty?</li> </ul>	plan's fidelity bo	ond, that was caused	10d		×			
Were any fees or commissions paid to any brokers, agents     corrige insurance service or other organization that provid	, or other person	ns by an insurance		x		620		

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	х		62688
f	Has the plan failed to provide any benefit when due under the plan?	10f		X	
q	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	Х		153662
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			

Form 5500-SF 2017

Page 3-	1
Fage J-	

Part	VI Pension Funding Compliance	_				
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Scl (Form 5500) and line 11a below)	nedule S	B		Yes X	] No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a				
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA?	on 302 o	f		Yes X	No
a	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, an granting the waiver.	d enter Da		of the lett Year	ter rulin	g
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				
	Enter the amount contributed by the employer to the plan for this plan year	12c				
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d				
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No	N/	A
Part						
-	Has a resolution to terminate the plan been adopted in any plan year?		Yes	X	No	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a				
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	9	. [	Yes	X No	
с	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(which assets or liabilities were transferred. (See instructions.)	s) to				
	13c(1) Name of plan(s): 13c(2	2) EIN(s)		13c	(3) PN(	s)