For	rm 5500-SF	Short Form Annua	oyee	OMB Nos. 1210-0110 1210-0089							
	rtment of the Treasury nal Revenue Service	This form is required to be filed	Benefit Plan under sections 104 and 4	065 of the Employee Re	etirement	2017					
	epartment of Labor enefits Security Administration	Income Security Act of 1974 (E		7(b) and 6058(a) of the		This Form is Open to Public Inspection					
Pension Be	enefit Guaranty Corporation	-	Complete all entries in accordance with the instructions to the Formattion of the								
Part I											
For calenda	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017 Image: single-employer plan Image: a multiple-employer plan (not multiemployer) (Filers checking this box must attach a										
A This ret	urn/report is for:	x a single-employer plan	list of participating em			king this box must attach a /ith the form instructions.)					
R This rote	urn/report is	a one-participant plan	a foreign plan								
		the first return/report									
		an amended return/report	a short plan year return	n/report (less than 12 mo	onths)						
C Check I	box if filing under:	X Form 5558	automatic extension	[DFVC p	rogram					
	special extension (enter description)										
Part II		rmation—enter all requested info	rmation								
1a Name	of plan . MEDICAL CENTRE F				1b Thre	e-digit number					
				-	(PN)						
			1c Effect	tive date of plan 01/01/2017							
		ver, if for a single-employer plan)			2b Employer Identification Number						
City or	town, state or province	n, apt., suite no. and street, or P.O. e, country, and ZIP or foreign postal		uctions)	(EIN) 65-1142585						
UNIVERSAL	MEDICAL CENTRE, F	P.A.			2c Sponsor's telephone number 305-893-8306						
					2d Business code (see instructions)						
13377 WEST MIAMI, FL 33	F DIXIE HIGHWAY 3161				621111						
3a Plan a	dministrator's name an	d address X Same as Plan Spons	or.		3b Administrator's EIN						
					3c Administrator's telephone number						
		plan sponsor or the plan name has			4b EIN						
•	an, enter the plan spor or's name	nsor's name, EIN, the plan name and	d the plan number from th	ie last return/report.	4d PN						
C Plan N	lame										
5 a Totol ·	number of participants	at the beginning of the plan year			5a	5					
		at the end of the plan year			5b	7					
C Numb	er of participants with a	account balances as of the end of th	e plan year (only defined	contribution plans	5c 7						
•	,	ticipants at the beginning of the plar			5d(1)	5					
• •	•	ticipants at the end of the plan year	•		5d(2)	7					
e Numb	per of participants who	terminated employment during the p	plan year with accrued be	nefits that were less	5e	0					
than Caution: A	100% vested	or incomplete filing of this return/	report will be assessed	unless reasonable cau		blished.					
Under pena	alties of perjury and oth	er penalties set forth in the instructi	ons, I declare that I have	examined this return/rep	oort, includi	ng, if applicable, a Schedule					
	edule MB completed an true, correct, and comp	d signed by an enrolled actuary, as lete.		sion of this return/report	, and to the	e best of my knowledge and					
SIGN	Filed with authorized/	valid electronic signature.	10/09/2018	SMITH JOSEPH							
HERE	Signature of plan a	dministrator	Date	Enter name of individu	ual signing	as plan administrator					
SIGN											
HERE	Signature of employ	yer/plan sponsor	Date	Enter name of individu	al signing	as employer or plan sponsor					

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Form 5500-SF (2017) v.170203

6a	a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)										
b											
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) 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	C If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No										
Ŭ	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year										
Pa	Part III Financial Information										
7	Plan Assets and Liabilities		(a) Beginning o	of Year			of Year				
а	Total plan assets	7a		0			3000				
b	Total plan liabilities	7b									
C	Net plan assets (subtract line 7b from line 7a)	7c		0			30000				
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) T	otal			
а	Contributions received or receivable from:										
	(1) Employers	8a(1)		16982	_						
	(2) Participants	8a(2)	1	13018	_						
<u> </u>	(3) Others (including rollovers)	8a(3)			_						
b	Other income (loss)	8b									
· · · ·	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			_			30000			
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d									
е	Certain deemed and/or corrective distributions (see instructions)	8e									
f	Administrative service providers (salaries, fees, commissions)	8f									
g	Other expenses	8g									
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h									
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						30000			
j	Transfers to (from) the plan (see instructions)	8j									
Ра	rt IV Plan Characteristics										
9a	If the plan provides pension benefits, enter the applicable pension $2A$ $2E$ $2J$ $3D$	feature co	odes from the List of Pla	an Char	acteris	stic Co	odes in the inst	ructions:			
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature coo	des from the List of Plar	n Chara	cterist	ic Cod	les in the instru	ictions:			
Par	t V Compliance Questions										
10	During the plan year:				Yes	No	ļ	Amount			
а	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)		,	10a		х					
b	Were there any nonexempt transactions with any party-in-interest			TVa		~					
	reported on line 10a.)			10b		Х					
C	Was the plan covered by a fidelity bond?			10c		Х					
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		x					
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		Х					
f				10f		Х					

Х

Х

10g

10h

10i

g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)

h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR

i

2520.101-3.)

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.....

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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	ls t ERI (If '	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	1 ×	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	:(3) P	'N(s)

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Oct.	9. 2018 1:	58 P M			No.	2008 P. 1/7		
	m 5500-SF	Short Form Annu	al Return/Report Benefit Plan	of Small Emplo	byee	OMB Nos. 1210-0110 1210-0089		
Interna	al Revenue Service	This form is required to be file	d under sections 104 and 4	065 of the Employee Re	tirement	2017		
Employee Ber	pertment of Labor nefits Security Administration nefit Guaranty Corporation		Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of t Revenue Code (the Code).					
Part I		 Complete all entries in a t Identification Information 	accordance with the instru	uctions to the Form 55	00-SF.	Public Inspection		
	r plan year 2017 or	fiscal plan year beginning 01/01/201	17	and ending 12/3	1/2017			
	m/report is for:	a single-employer plan	a multiple-employer pla	п (not multiemployer) (F	ilers checkin	ng this box must attach a h the form instructions.)		
B This retur	rn/report is	∑ the first return/report	the final return/report					
		an amended return/report		/report (less than 12 mo	manths)			
C Check b	ox if filing under:			roport (1000 than 12 m				
O OHECK D	ox ir nimg onder.	X Form 5558	automatic extension	ļ	DFVC pro	ogram		
Dentu	Decie Dien Inf	special extension (enter descr	statu sidat					
Part II 1a Name o		ormation—enter all requested int	formation		46 These			
	dical Centre PA 401	(k) Plan			1b Three- plan n	umber		
				_	(PN)	A		
					1C Effecti 01/01/	ve date of plan /2017		
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)					2b Employer Identification Number (EIN) 65-1142585			
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Universal Medical Centre, P.A.					2c Sponsor's telephone number (305) 893-8306			
13377 West C					2d Busine	ss code (see instructions)		
Miami, FL 331 3a Plan ad		and address 🗙 Same as Plan Spor	1501.		3b Admin	istrator's EIN		
				-	3¢ Admin	istrator's telephone number		
4 If the na	and and/or EIN of th				44			
		ne plan sponsor or the plan name ha onsor's name, EIN, the plan name a			4b EIN			
a Sponso C Plan Na				1 21 42494434344444	4 d PN	사업의, 14 17년 - 13		
		s at the beginning of the plan year		- F	5a	5		
		s at the end of the plan year			5b			
C Numbé comple	er of participants with the this item)	account balances as of the end of	the plan year (only defined	contribution plans	5c	7		
		articipants at the beginning of the pl			5d(1)	5		
d(2) ⊤ota	I number of active p	articipants at the end of the plan yea	ar		5d(2)	7		
e Numbe	er of participants wh	o terminated employment during the	e plan year with accrued ber	hafits that were less	5e	Û		
Caution: A Under penal SB or Sched	penalty for the late Ities of perjury and c	or Incomplete filing of this return other penalties set orth in the instruct and signed by an enrolled actuary, a molete.	n/report will be assessed a tions. I declare that I have	Inless reasonable cau examined this return/rec	ort. including	a, if applicable, a Schedule		
SIGN		100 100		Smith Joseph		1967 - 20 March 1967 - 2017 -		
HERE	Signature of plan	Korning Art	Date 10 9.18	Enter name of individu	uat signing as	s plan administrator		
HERE	Signature of error	lover/plan sponsor	Date	Enter name of individu	al signing or	s employer or plan sponsor		
For Paperwo	rk Reduction Act Not	Ice, see the Instructions for Form 5500			ໝ ອາສີເຫເລີ ຊະ	Form 5500-SF (2017) v.170203		

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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.)

Pa	rt III Financial Information		8						
7	Plan Assets and Liabilities		(a) Beginning (of Year		N.	(b) End of Ye	ar	
<u>a</u>	Total plan assets	7a			0			30000	
b	Total plan liabilities	7b	-						
с	Net plan assets (subtract line 7b from line 7a)	7c			0			30000	
8	Income, Expenses, and Transfers for this Plan Year	с ознало (С. 1996) 19 — 19 — 19 — 19 — 19 — 19 — 19 — 19 —	(a) Amoun	(a) Amount			(b) Total		
a	Contributions received or receivable from; (1) Employers	8a(1)		16982					
	(2) Participants	. <u>8a(</u> 2)		130	18			•	
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b				5.7			
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						30000	
d	Benefits pald (including direct rollovers and insurance premiums to provide benefits)	8d				9.6 10	2		
e	Certain deemed and/or corrective distributions (see instructions)	80	-		2			1	
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f	201 D				÷		
_9	Other expenses	8g	2 1 1			-2		······	
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	81		8			1) (c)	30000	
j	Transfers to (from) the plan (see instructions)	8i						N. 3.	
Pa	t IV Plan Characteristics								
b Par	If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 3D If the plan provides welfare benefits, enter the applicable welfare fe t V Compliance Questions						53		
10	During the plan year:				Yes	No	Amou	nt	
2	Was there a failure to transmit to the plan any participant contribut described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	10a		x	Allos	<u></u>	
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not i	include transactions	10b		×			
C	Was the plan covered by a fidelity bond?			10c		X			
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bo	nd, that was caused	10d		x			
e	Were any fees or commissions paid to any brokers, agents, or oth camer, insurance service, or other organization that provides som the plan? (See instructions.)	er person: e or all of	s by an insurance the benefits under	10e		×	2		
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		x			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-e	and.)	10g		x			
h	If this is an individual account plan, was there a blackout period? (2520,101-3.)			10h		×	÷ .		
I		ne required	I notice or one of the	10i			R ⁱⁿ		

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No.2008 P. 2/7

	Form 5500-SF 2017		Page 2	2					
b	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to elther line 6a or line 6b, the plan cann If the plan is a defined benefit plan, is it covered under the PBGC in	an independ and condition lot use Form hsurance pro-	dent qualified public a ns.) m 5500-SF and must ogram (see ERISA se	ccounta t instea	ant (IQ I <mark>d use</mark> 021)?	PA) Form 5500		Yes .	No No ed
	If "Yes" is checked, enter the My PAA confirmation number from th	e PBGC pre	emium filing for this pl	an year			<u> </u>	ee instruction	.s.)
Pa	t III Financial Information	100							
	Plan Assets and Liabilities		(a) Beginning c	of Year			(b) End of	Year	
	Total plan assets	7a			0			30000	
19.20	Total plan liabilities	76							
	Net plan assets (subtract line 7b from line 7a)	7c			0			30000	
	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Totz	l	
а	Contributions received or receivable from; (1) Employers	8a(1)		1698	2		10 - 10 - 10 - 1	2. 10	2.5
-	(2) Participants	8a(2)		1301			- 6-4	- • • <u>·</u>	12
	(3) Others (including rollovers)	8a(3)			- F			te di j	7
	Other income (loss)	8b				8.7 5.7			
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		97		22		30000	
d	Benefits pald (including direct rollovers and insurance premiums					20			_
	to provide benefits)	8d	<u> </u>	0	_		<u></u> /		
17.95	Certain deemed and/or corrective distributions (see instructions)	80			_		_	1	
61 - 30%	Administrative service providers (salaries, fees, commissions)	8f	0		_			· · · · ·	
C 2020 (C)	Other expenses	8g			-	2			3
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					18		
	Net income (loss) (subtract line 8h from line 8c)	81	P.C.					30000	
1	Transfers to (from) the plan (see instructions)	8j			_				
Name of Street or other	t IV Plan Characteristics If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 3D If the plan provides welfare benefits, enter the applicable welfare for								
Par	t V Compliance Questions	122			/2//2				0
10	During the plan year:		5.8°.		Yeş	No	Am	ount	
2	Was there a failure to transmit to the plan any participant contribut described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary Fic	duciary Correction	10a		x			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not in	clude transactions	10ь		x		(2)	
C	Was the plan covered by a fidelity bond?			10c		×	0		
d	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			
ê	양도 그렇을 모양 것 것 같은 것			10e		×	÷		
f						×			<u></u>
g				10g		x			
h	2520,101-3.)			10h		×	8		
1	If 10h was answered "Yes," check the box if you either provided th exceptions to providing the notice applied under 29 CFR 2520.10	ne required i	notice or one of the	10i			ş		