Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans 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.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

Part I Annual Report I	dentification Information					
For calendar plan year 2017 or fis	cal plan year beginning 07/01/2017	and ending 06/30/201	8			
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accordance)			ns.)	
	X a single-employer plan	a DFE (specify)				
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 i	months)			
C If the plan is a collectively-barg	gained plan, check here			• [
D Check box if filing under:	X Form 5558	automatic extension	the DFVC program			
special extension (enter description)						
Part II Basic Plan Infor	mation—enter all requested inform	aation				
1a Name of plan LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, WELFARE PLAN					501	
	1c	Effective date of pla 12/01/2006	an			
2a Plan sponsor's name (employ Mailing address (include room City or town, state or province	2b	2b Employer Identification Number (EIN) 59-3522082				
LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, LLC			2c	2c Plan Sponsor's telephone number 352-365-2857		
SUITE 112 734 N 3F		EDICAL IMAGING RD ST RG, FL 34748-5287		Business code (see instructions) 621399	e	

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 accompanying schedules, statements and attachments, 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. Signature of plan administrator	03/15/2019 Date	CHUCK BENTLY Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	03/15/2019 Date	CHUCK BENTLY Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203

		- 0		
3a	Form 5500 (2017) Plan administrator's name and address X Same as Plan Sponsor	Page 2	3b Administrato	r's EIN
			3c Administrator number	r's telephone
4 a	If the name and/or EIN of the plan sponsor or the plan name has changed since the last enter the plan sponsor's name, EIN, the plan name and the plan number from the last re Sponsor's name LAKE MEDICAL IMAGING		4b EIN 4d PN	
	Plan Name			
5	Total number of participants at the beginning of the plan year		5	191
6	Number of participants as of the end of the plan year unless otherwise stated (welfare pl 6a(2), 6b, 6c, and 6d).	ans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		<mark>6a(1)</mark>	191
a(2) Total number of active participants at the end of the plan year		6a(2)	193
b	Retired or separated participants receiving benefits		6b	
	Other retired or separated participants entitled to future benefits		6c	102
	Subtotal. Add lines 6a(2) , 6b , and 6c		6d 6e	193
f	Total. Add lines 6d and 6e .		6f	
g	Number of participants with account balances as of the end of the plan year (only define complete this item)		6g	
h	Number of participants who terminated employment during the plan year with accrued be less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemploy	er plans complete this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature codes from the If the plan provides welfare benefits, enter the applicable welfare feature codes from the 4B 4D 4E 4F 4H			
	(1) X Insurance (1) (2) Code section 412(e)(3) insurance contracts (2) (3) Trust (3) (4) X General assets of the sponsor (4)	benefit arrangement (check all th Insurance Code section 412(e)(3) Trust X General assets of the s	insurance contract	
	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and Pension Schedules b Gen	d, where indicated, enter the numleral Schedules	ber attached. (See	instructions)
a	(1) R (Retirement Plan Information) (1)	H (Financial Infor	mation)	
	(1)	H	mation – Small Plar	n)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan (3)	X 4 A (Insurance Info		,

(4) (5)

(6)

SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)						
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)							
11b Is the	11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)						
Rece	ipt Confirmation Code						

Form 5500 (2017)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2017

nursuant to FDICA continu 402(a)(2)					m is Open to Public Inspection		
For calendar plan year 20	17 or fiscal pl	an year beginning 07/01/2017		and en	iding 06/3	0/2018	
A Name of plan LAKE MEDICAL IMAGINO	G & BREAST	CENTER AT THE VILLAGES, V	VELFARE PLAN		e-digit number (PN	J) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, LLC D Employer Identification Number (EII 59-3522082						(EIN)	
on a separa		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca RELIANCE STANDARD	rrier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n			•	ontract year
(b) LIN	code	identification number	policy or contract		(f)	From	(g) To
36-0883760	68381	LTD 126315	129	9	07/01/2017	7	06/30/2018
2 Insurance fee and come descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, I	brokers, and c	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
5536 0						0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
-	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
LASSITER WARE			MAITLAND CENTER PA LAND, FL 32751	ARKWAY			
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
5536				3			
	(a) Name	and address of the agent, broke	r or other person to who	m commiss	ions or fees	were paid	
	(a) Hame	and address of the agent, protect	r, or one, percente une		1000	were para	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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P	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such conti	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	· · · · · · · · · · · · · · · · · · ·	-	
	а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	- H	L	Supplemental unen	anloymont	h Prescription drug
			f X Long-term disabilit			ipioyment	
	ן י	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:	!	- (1)	1		_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res	•	9a(3)		00(4)	
	b	(4) Earned ((1) + (2) - (3))		9b(1)		9a(4)	
	D	(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
	-	(A) Commissions	•	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	·· 9c(2)	
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				` '	
4.0	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	<u>).)</u>	9e	
10	_	nexperience-rated contracts:				100	0044
	a	Total premiums or subscription charges paid to c				<u>10a</u>	2214
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	
	Spe	cify nature of costs.					
P	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ete Schedul	е А?	Yes	X No
		he answer to line 11 is "Yes," specify the informati		cie ocnedul	о д:		<u></u>
1 4		ne answer to line in is nes, specify the informati	on not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 201	17 or fiscal plan	year beginning 07/01/2017		and en	ding 06/3	0/2018	
A Name of plan LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, WELFARE PLAN					e-digit number (PN	۷) 🕨	501
C Plan sponsor's name a LAKE MEDICAL IMAGINO		e 2a of Form 5500 ENTER AT THE VILLAGES, LLC	;	-	yer Identific 3522082	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car RELIANCE STANDARD	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
36-0883760	68381	G 164172	151		07/01/2017	7	06/30/2018
2 Insurance fee and communication descending order of the		tion. Enter the total fees and total	ıl commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	mount of comn			(b) To	tal amount	of fees paid	
		3242					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	•		ions or fees	were paid	
LASSITER WARE			AITLAND CENTER PA .ND, FL 32751	RKWAY			
(b) Amount of sales an	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose		(e) Organization code	
	3242						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		V .	·			·	
(b) Amount of sales an	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose				(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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Pa	art I	III Welfare Benefit Contract Informat	tion					
		If more than one contract covers the same granthe information may be combined for reporting employees, the entire group of such individual.	ng purposes if such contr	acts are expe	erience-rated as a unit	t. Where co	ontracts cover in	
8	Bene	nefit and contract type (check all applicable boxes)			<u> </u>			
	аΓ		b Dental	с	Vision		d Life insur	ance
	e >		f Long-term disabilit	<u> </u>	Supplemental unem	nlovmont	h Prescript	
	. r		<u></u>	·	3	pioyinent		_
	'	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity	y contract
	m	Other (specify)						
		erience-rated contracts:	1					
		Premiums: (1) Amount received	•	9a(1)				
		(2) Increase (decrease) in amount due but unpaid.		9a(2)				
		(3) Increase (decrease) in unearned premium rese	_	9a(3)		0-(4)		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid		9b(1) 9b(2)				
		(2) Increase (decrease) in claim reserves				9b(3)		
		(4) Claims charged				9b(3) 9b(4)		
		Remainder of premium: (1) Retention charges (on				35(4)		
	Ū	(A) Commissions	-	9c(1)(A)			_	
		(B) Administrative service or other fees	•	9c(1)(B)				
		(C) Other specific acquisition costs	•	9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	la contraction of the contractio					
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entered	I in line 9c(2)	.)	. 9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		43230
	_	If the carrier, service, or other organization incurre retention of the contract or policy, other than report	, .		•	. 10b		
	_		, .		•	10b		
11		IV Provision of Information d the insurance company fail to provide any informathe answer to line 11 is "Yes," specify the information		ete Schedule	• A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 2017 or fiscal plan year beginning 07/01/2017 and ending 06/30/2018							
A Name of plan LAKE MEDICAL IMAGING	G & BREAST C	ENTER AT THE VILLAGES, WE	ELFARE PLAN	B Three plan	e-digit number (PN	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, LLC D Employer Identification Number (EIN) 59-3522082						EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca RELIANCE STANDARD	rrier						
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
36-0883760	68381	GL 154290	193	3	07/01/2017	7	06/30/2018
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total a	amount of comr			(b) To	tal amount	of fees paid	
		8629					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,			ions or fees	were paid	
LASSITER WARE			AITLAND CENTER PA ND, FL 32751	RKWAY			
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	8629						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		<u> </u>				·	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			. \Box		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

F	art	If more the info	than one contract covers the same ormation may be combined for reportees, the entire group of such individual.	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Ben		act type (check all applicable boxes)		anor may be	irodiod do d dilli for pe	a. pocoo o	
Ŭ	a [_	er than dental or vision)	b Dental	с□	Vision		d X Life insurance
	 F	₫ `	,	. H		!		_
	е	=	disability (accident and sickness)	f Long-term disabilit	· ~ <u> </u>	Supplemental unemp	ployment	h Prescription drug
	i	Stop loss (I	large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (spe	cify) 🕨					
		_						
9	Expe	rience-rated	contracts:					
	a I	Premiums: (1)	Amount received		9a(1)			
		(2) Increase	(decrease) in amount due but unpai	d				
			(decrease) in unearned premium re					
			1) + (2) - (3))				9a(4)	
	b	•	ges (1) Claims paid					
			(decrease) in claim reserves				21 (2)	
			claims (add (1) and (2))				9b(3)	
	_	` '	narged				9b(4)	
	С		of premium: (1) Retention charges (0-(4)(4)			
		` ,	missions					
		` ,	nistrative service or other fees		0 (4)(0)			
		` '	r specific acquisition costs		0 (4)(5)			
		` '	r expensess		0 (4)(=)			
			ges for risks or other contingencies					
		(G) Othe	r retention charges		9c(1)(G)			
			retention				9c(1)(H))
		` ,	s or retroactive rate refunds. (These					
	d		icyholder reserves at end of year: (9d(1)	
	_	•	serves	'			9d(2)	
		` '	serves				9d(3)	
	е	` '	retroactive rate refunds due. (Do r				9e	
10			rated contracts:		` ` `	,	•	
	а	Total premiu	ms or subscription charges paid to	carrier			10a	86294
	b		service, or other organization incur he contract or policy, other than rep				10b	
		cify nature of	costs.	orted iii i arti, iiie 2 abov	e, report amo	UII		
P	art l	V Prov	rision of Information					
11	Dic	the insuranc	e company fail to provide any inforr	nation necessary to compl	ete Schedule	A?	Yes	X No
12	2 If the	ne answer to	line 11 is "Yes," specify the information	tion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

				Inspection			
For calendar plan year 2017 or fiscal plan year beginning 07/01/2017 and ending 06/30/2018					0/2018		
A Name of plan LAKE MEDICAL IMAGING	G & BREAST C	CENTER AT THE VILLAGES, WE	ELFARE PLAN		e-digit number (PN	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 LAKE MEDICAL IMAGING & BREAST CENTER AT THE VILLAGES, LLC D Employer Identification Number (EIN) 59-3522082						EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance car RELIANCE STANDARD	rrier						
/ L \	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
36-0883760	68381	136-003315	192	2	12/01/2017	7	06/30/2018
2 Insurance fee and compute descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr			(b) To	otal amount	of fees paid	
		4317					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	•	m commiss	ions or fees	were paid	
LASSITER-WARE INC			X 490690 URG, FL 34749-0690				
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
	4317						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
LASSITER-WARE INSURA		2701 M	AITLAND CENTER PA AND, FL 32751				
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
							3
For Donomicals Doductio	n Act Notice	see the Instructions for Form F	F00			Cabaa	lulo A (Eorm 5500) 2017

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

Р	art	III Welfare Benefit Contract Inform	ation				
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the contract covers the same the contract covers the same the covers the contract covers the same the covers the contract covers the cov	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	·		· · · ·
	а	Health (other than dental or vision)	b X Dental	c	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental unen	anlaymant	h Prescription drug
				- 5		прюутнети	
	ן י	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:			1		
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpair		9a(2)			
		(3) Increase (decrease) in unearned premium res	•			0=/4)	
	h	(4) Earned ((1) + (2) - (3))	i			9a(4)	
	b	Benefit charges (1) Claims paid		(-)			_
		(2) Increase (decrease) in claim reserves	· ·			9b(3)	
		(4) Claims charged				9b(3)	
	С	Remainder of premium: (1) Retention charges (c		•••••		35(4)	
	·	(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			_
		(D) Other expenses		0.741701			
		(E) Taxes		0 (4)(5)			
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges					
		(H) Total retention	•			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	_				
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			10a	19329
	b	If the carrier, service, or other organization incur					
	C	retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report am	ount	10b	
	Spe	cify nature of costs.					
P	art	IV Provision of Information					
				ata California I	- A2 F	Yes	X No
11		d the insurance company fail to provide any inform		ete Schedul	e A?	162	<u> </u>
12	! If t	he answer to line 11 is "Yes," specify the informat	ion not provided.				

Form **5558**(Rev. August 2012)

,

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.
Information about Form 5558 and its instructions is at www.irs.gov/form5558

OMB No. 1545-0212

File With IRS Only

	ent of the Treasury Revenue Service Information about Form 5558 and its instruction	ns is at www.irs.gov	/form5558				
Pari	I Identification						
:	Name of filer, plan administrator, or plan sponsor (see instructions) Lake Medical Imaging & Breast Center at the Villages, LLC Number, street, and room or suite no. (If a P.O. box, see Instructions)	1	fying number (s ntification numbe 2		•		
	341 Oak Terrace Drive Suite 112 City or town, state, and ZIP code Leesburg FL 34748	Social securit	Social security number (SSN) (9 digits XXX-XX-XXXX)				
С	Plan name	Plan number	Plan year ending				
:	Lake Medical Imaging & Breast Center at the Villages, Welfare Pla		06 -	30	2018		
Part	II Extension of Time To File Form 5500 Series, and/or Form 895	5-SSA			- <u>-</u>		
1	Check this box if you are requesting an extension of time on line 2 to file in Part 1, C above.	the first Form 5500 s	eries return/re	eport for the p	olan listed		
2	I request an extension of time until 04 / 15 / 2019 to file Form Note. A signature IS NOT required if you are requesting an extension to file in	n 5500 series (see in Form 5500 series.	structions).				
3	I request an extension of time until 04 / 15 / 2019 to file Form Note. A signature IS NOT required if you are requesting an extension to file to	n 8955-SSA (see ins Form 8955-SSA.	tructions).				
	The application is automatically approved to the date shown on line 2 and/the normal due date of Form 5500 series, and/or Form 8955-SSA for which the and/or line 3 (above) is not later than the 15th day of the third month after the	his extension is requ					
Part	Extension of Time To File Form 5330 (see instructions)						
4	I request an extension of time until / / to file Form You may be approved for up to a 6 month extension to file Form 5330, after the second sec		of Form 5330.				
а	Enter the Code section(s) imposing the tax	. ▶ <u>a</u>		··			
b	Enter the payment amount attached		. , •	b			
с 5	For excise taxes under section 4980 or 4980F of the Code, enter the reversion State in detail why you need the extension:	on/amendment date .	. •	С			
	•						

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature Kuskin M. A.

Date > /-3/-/9

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans 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.

OMB Nos. 1210-0110 1210-0089

2017

			Inspection	, i abiio				
Part I Annual Report Identification Information								
For calendar plan year 2017 or fiscal plan year beginning 07/01/2017 and ending 06/30/2018								
A This return/report is for: a multiemployer plan; a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instruction								
X a single-employer plan;	a DFE (specify	<i>'</i>)						
B This return/report is:	the final return	the final return/report;						
an amended return/report;	a short plan ye	a short plan year return/report (less than 12 months).						
C If the plan is a collectively-bargained plan, check here								
D Check box if filing under: X Form 5558;	automatic exte	ension;	the DFVC pr	ogram;				
special extension (enter des	_		ш .					
Part II Basic Plan Information enter all request	ted information		<u> </u>					
1a Name of plan			1b Three-digit plan					
Lake Medical Imaging & Breast Center at	the Villages, Welf	are Plan	number (PN) ▶	501				
1c Effective date of plan 12/01/2006								
Plan sponsor's name (employer, if for a single-employer plan Mailing address (include room, apt., suite no. and street or P City or town, state or province, country, and ZIP or foreign po	2b Employer Identification Number (EIN) 59-3522082							
Lake Medical Imaging & Breast Center at		2c Plan Sponsor's telephone number (352) 365-2857						
341 Oak Terrace Drive Lake	Medical Imaging		e					
Suite 112 734 N	3RD St		instructions)					
US Leesburg FL 34748 US Le	esburg FL 34748-5287	621399						
				:				
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 accompanying schedules, statements and attachments, 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 Chilled	3-14-19	Chuck Bentley	- 					
Signature of plan administrator	Date	Enter name of individual s	ning as plan administrator					
SIGN HERE Und Rede	3-14-19	-/9 Chuck Bentley						
Signature of employer/plan sponsor	Date	Enter name of individual s	signing as employer or plan	sponsor				
SIGN HERE								
Signature of DFE	Date	Enter name of individual s	signing as DFE					

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

Form 5500 (2017) v. 170203

_	Form 5500 (2017)			Pag	qe 2			
3a	Plan administrator's name and address X Same as Plan Sponsor					3b Adn	ninistrator's EIN	
							ninistrator's telephone nber	
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the enter the plan sponsor's name, EIN and the plan name and the plan number					4b €IN	<u> </u>	
	Sponsor's name Lake Medical Imaging Plan name					4d PN		
5	Total number of participants at the beginning of the plan year					5		
6	Number of participants as of the end of the plan year unless otherwise state 6a(2), 6b, 6c, and 6d).	ed (welfa	are pla	ans c	omplete only lines 6a(1),			
a(1) Total number of active participants at the beginning of the plan year					6a(1)	191	
a(2) Total number of active participants at the end of the plan year					6a(2)	193	
b	Retired or separated participants receiving benefits		•			6b		
С	Other retired or separated participants entitled to future benefits					6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c					6d	193	
e	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive b	enefit	s		6e		
f	Total, Add lines 6d and 6e		. ,			6f		
g	Number of participants with account balances as of the end of the plan year complete this item)					6g		
h 	Number of participants who terminated employment during the plan year wiless than 100% vested					6h		
7	Enter the total number of employers obligated to contribute to the plan (only If the plan provides pension benefits, enter the applicable pension feature					7		
k	If the plan provides welfare benefits, enter the applicable welfare feature c	odes fro	om the	e List	of Plan Characteristics Coo	des in the i		
уа	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) Insurance contracts (3) Trust (4) X General assets of the sponsor		(1) (2) (3) (4)	bene X	fit arrangement (check all the Insurance Code section 412(e)(3) in Trust General assets of the sp	nsurance c	contracts	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attach	ned, and,	· -	e indic			nstructions)	
а	Pension Schedules (1) R (Retirement Plan Information)	b	Gene	ral S	chedules H (Financial Info	rmation)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) (3) (4)	x	I (Financial Info 4 A (Insurance Info C (Service Provi	ormation)	,	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(5) (6)		D (DFE/Participa G (Financial Tra			

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan p	provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR)				
If "Yes" is checked, complete lines 11b and 11c.					
11b Is the plan	currently in compliance with the Form M-1 filling requirements? (See instructions and 29 CFR 2520.101-2.)				
enter the R	eceipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, eceipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to d Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Receipt Co	nfirmation Code				

Page 3

Form 5500 (2017)

E-SIGNATURE AUTHORIZATION

for

Lake Medical Imaging & Breast Center at the Villages, Welfare Plan 59-3522082/501

For Plan Year 07/01/2017 through 06/30/2018

I/We, the undersigned, understand that a 5500 Series filing for the plan listed above must be prepared, electronically signed and electronically transmitted to the EBSA Electronic Filing Acceptance System (EFAST).

I/We authorize LassiterWare to electronically sign the 5500 Series filing on my/our behalf and to transmit that signed form to EFAST on or before the filing due date.

I/We understand that by granting this authority:

- A manually signed and dated Form 5500 that has been provided must be returned to
 LassiterWare before they can begin the electronic filing process. I/We will retain a copy of this
 manually signed form and any schedules and attachments in the plan records.
 - LassiterWare will not be responsible for any late filing penalty assessed under ERISA should
 I/we not return the manually signed and dated Form 5500 prior to the filing due date.
- An electronic copy of the manually signed and dated Form 5500 showing my/our signatures
 will be included in the electronic filing and will be posted by the EBSA to the Internet for
 public disclosure.
- LassiterWare will maintain a copy of this written authorization in its records.
- LassiterWare will notify all signers about any inquiries and correspondence it receives about this filing from EFAST, EBSA, IRS or PBGC.
- LassiterWare shall not be deemed to be a plan fiduciary with respect to this plan solely on account of providing the electronic signature and filing of the 5500 for the plan year listed above.

She Bark,	Ant But
Plan Administrator	Plan Sponsor
3-14-19	3-14-19
Date	Date