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

Parti	Annual Repor	t identification informatio	n								
For calend	lar plan year 2017 or t	fiscal plan year beginning 12/01	/2017	and ending 1	1/30/2018						
A This re	turn/report is for:	a single-employer plan		plan (not multiemployer) (employer information in ac	_						
			,								
B This ret	urn/report is										
		an amended return/report	report a short plan year return/report (less than 12 months)								
C Check	box if filing under:	Form 5558	automatic extension	n	DFVC prograi	m					
		special extension (enter des	. ,								
Part II	Basic Plan Inf	ormation—enter all requested	information								
1a Name MEDICAL S	•	NTUCKIANA, PLLC DEFINED BE	NEFIT PLAN		1b Three-digiting plan numb (PN) ▶						
					1c Effective d	ate of plan 12/01/2004					
		oyer, if for a single-employer plan				dentification Number 61-1456454					
-	r town, state or provin	ice, country, and ZIP or foreign po	stal code (if foreign, see in	structions)	2c Sponsor's telephone number 502-896-6166						
						code (see instructions)					
1013 DUPO SUITE A	NT SQUARE NORTH	ł			621111						
LOUISVILLE	E, KY 40207										
3a Plan a	administrator's name a	and address X Same as Plan Sp	onsor.		3b Administra	tor's EIN					
					3c Administra	tor's telephone number					
4 If the	name and/or EIN of the	ne plan sponsor or the plan name	has changed since the last	t return/report filed for	4b EIN						
this p		onsor's name, EIN, the plan name			4d PN						
C Plan N					4u PN						
5a Total	number of participant	s at the beginning of the plan year	٢		5a	5					
		s at the end of the plan year			5b						
		account balances as of the end o			5c						
d(1) Tot	tal number of active pa	articipants at the beginning of the	plan year		. 5d(1)						
d(2) Total number of active participants at the end of the plan year				. 5d(2)							
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 retu	ırn/report will be assesse	ed unless reasonable car							
SB or Sch		other penalties set forth in the instrance and signed by an enrolled actuary nolete.									
SIGN		d/valid electronic signature.	06/18/2019	VANI NADAR							
HERE	Signature of plan	administrator	Date	Enter name of individ	ual signing as pla	n administrator					
SIGN	Filed with authorize	d/valid electronic signature.	06/18/2019	KRISHNA NADAR							
HERE	l a: .										

Date

Enter name of individual signing as employer or plan sponsor

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	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 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.)							No No	
С	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 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year								
Pai	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End of Year		
а	Total plan assets	. 7a		81676			5474392		
b	Total plan liabilities	. 7b		0			0		
С	Net plan assets (subtract line 7b from line 7a)	. 7c	498	81676			5474392		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	nt			(b) Total		
а	Contributions received or receivable from: (1) Employers	. 8a(1)	28	85068					
	(2) Participants	. 8a(2)		0					
	(3) Others (including rollovers)	. 8a(3)		0					
b	Other income (loss)	. 8b	20	07648					
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	. 8c					492716		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d		0					
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	. 8e		0					
f	Administrative service providers (salaries, fees, commissions)	dministrative service providers (salaries, fees, commissions) 8f 0							
g	Other expenses 8g 0								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)								
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)								
j	Transfers to (from) the plan (see instructions)	- 8j		0					
Par	Part IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 1A 3D	feature co	odes from the List of Pl	an Cha	racteri	istic Co	odes in the instructions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	des from the List of Pla	n Chara	acteris	tic Coc	des in the instructions:		
Par	t V Compliance Questions								
10	During the plan year:				Yes	No	Amount		
а	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	Fiduciary Correction	10a		X	0		
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	t? (Do not	include transactions	10b		Х	0		
С	Was the plan covered by a fidelity bond?			10c		X	0		
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused				Х	0		
е	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.)						12558		
f	Has the plan failed to provide any benefit when due under the pla	in?		10f		Χ	0		
g		-		10g		X	0		
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)	······		10h		X			
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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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)							
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 302 of ERISA?							
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)						
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver			of the letter ruling Year			
lf y	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					
С	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							
Part '	VII Plan Terminations and Transfers of Assets						
13a	Has a resolution to terminate the plan been adopted in any plan year?		X 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 X No			
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)	to					
1	3c(1) Name of plan(s): 13c(2)	EIN(s)		13c(3) PN(s)			

From Medical Specialists Of Kentuckia 1.502.805.1974 Wed Jun 19 14:00:37 2019 EDT Page 3 of 5 Internal Revenue Service 2017

Department of Labor Employee Benefits Security Administration

Pension Sensift Guaranty Corporation

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).

This Form is Open Public Inspection

s cusion persuit acaism's coshoration	▶ Complete all entries in	accordance with the inst	ructions to the Form	5500-SF.	Lanue inspection
Part I Annual Report	Identification Information	1			
For calendar plan year 2017 or t	iscal plan year beginning	12/1/2017	and ending	11/30/20	18
A This return/report is for:	a single-employer plan a one-participant plan	a multiple-employer p list of participating er a foreign plan	lan (not multiemployer) mployer information in a	(Filers checking t	his box must attacr
B This return/report is		<u> </u>			
	the first return/report an amended return/report	the final return/report	m/report (less than 12 i	mantha)	
C Check box if filing under:	Form 5558	automatic extension	and a section of the		
	special extension (enter desc			DFVC progra	ភា
Part II Basic Plan Info	ormation—enter all requested is	nformation	**************************************		
1a Name of plan	ana, PLLC Defined Benefit Plan			1b Three-digiplan numb	
				1c Effective of	late of plan 1/2004
Mailing address (include roo	oyer, if for a single-employer plan) m. apt., suite no. and street, or P. e, country, and ZIP or foreign pos	O. Box) tal code (if foreign, coe inst	n orthograph	2b Employer (EIN) 61-	Identification Numb 1456454
Medical Specialists of Kentuckia	na, PLLC	res cone (a lotaldit! 200 litoi	ructions)		telephone number i02-896-5166
1013 Dupont Square North Suite A				2d Business	code (see instructio
Lauisville 40207	ΚΫ́			621	111
3a Plan administrator's name a	nd address 🗹 Same las Plan Spo	nsor.		3b Administra	tor's EIN
				3c Administra	tor's telephone nun
4 If the name and/or EIN of the this plan, enter the plan spo	e plan sponsor or the plan name hinsor's name, EIN, the plan name a	as changed since the last re and the plan number from the	eturn/report filed for ne last return/report	4b EIN	
a Sponsor's name c Plan Name		·		4d PN	***************************************
u rian waine					
5a Total number of participants	at the beginning of the plan year.	***************************************	100 200 100 100 100 100 100 100 100 100	5a	
b Total number of participants	at the end of the plan year		******************************	5b	
complete this item)	account balances as of the end of	the plan year (only defined	contribution plans	5c	19 th
d(1) Total number of active par	ficipants at the beginning of the pl	an year	************************	5d(1)	
 Q(Z) Total number of active par Number of participants who 	ticipants at the end of the plan ye.	ar	186,-2361626;	5d(2)	
man room vested	terminated employment during the			5e	
Under penalties of penury and ob-	er penalties sal forth in the install	vreport will be assessed	uniess reasonable ca		
S8 or Schedule M8 completed an belief, it is true correct, and comp	id signed by an enrolled actuary, a lete.	is well as the electronic ven	examined this return/reportsion of this return/repor	port, including, if a t, and to the best of	pplicable, a Sched of my knowledge ar
SIGN CANADA		6/18/19	MAY	VADAR	
Signature of plan ac	dministrator	Date	Enter name of individ	ual signing as plar	administrator
SIGN (9)	Madai	6/18/19	Krishno		lar
Signature of employ For Paperwork Reduction Act Notice	see the Instructions (m. F.	Date	Enter name of individ-	ual signing as emp	loyer or plan soons

	From Medical Specialists Of Kentuckia 1.502	.805.1974	Wed Jun 19 14	:00:37	7 201	9 ED7	Γ Page 4 of 5		
6a b	Were all of the plan's assets during the plan year invested in eligi Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility	f an indepen y and condition	dent qualified public	accoun	itant (K	QPA)	**************************************	Yes [
_	If you answered "No" to either line 6a or line 6b, the plan can								
C	If "Yes" is checked, enter the My PAA confirmation number from t							Not determ	
		and I boo by	ennour marg ior ans	han ye	at			e instruct	
Pa	rt III Financial Information	Control of the Contro	····				***************************************		
7	Plan Assets and Liabilities		(a) Beginning	of Yea	F.		(b) End of Y	еаг	
_ <u>a</u>	Total plan assets	7a		49	31676	~~~		547439	
<u>d</u>	Total plan liabilities	7b			Q				
C	Net plan assets (subtract line 7b from line 7a)	7c		498	31676			547439	
8	Income, Expenses, and Transfers for this Plan Year		(а) Атои	nť		~~~~	(b) Total		
a	Contributions received or receivable from:						\\ \frac{1}{2}		
	(1) Employers	. 8a(1)	***************************************	28	5068				
	(2) Participants.	. 8a(2)			Ď				
	(3) Others (including rollovers)	8a(3)		·	0)			
b	Other income (loss)	. 8b		20	7648				
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	. 8c						49271	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. Bd	0			\ X			
e	Certain deemed and/or corrective distributions (see instructions)	. 8e	0						
f	Administrative service providers (salaries, fees, commissions)	. 8f		***************************************	c	******			
g	Other expenses	. 8g		**********	01				
h	Total expenses (add lines 8d, 8e, 8f, and 8g)			illian.				<u>)</u>	
ì	Net income (loss) (subtract line 8h from line 8c)							492716	
j	Transfers to (from) the plan (see instructions)		8					4327,	
рa	rt IV Plan Characteristics	<u> 8j </u>		***************************************				******	
	If the plan provides pension benefits, enter the applicable pension 1A 3D	i feature cod	es from the List of P	ian Cha	racteri	stic Co	odes in the instruction	ons:	
b	if the plan provides welfare benefits, enter the applicable welfare	feature code	s from the List of Pla	n Chan	acteris	tic Cod	tes in the instruction	18:	
Par	t V Compliance Questions					***********		~~~~~	
10	During the plan year:				Yes	No	Amou	ınt	
a	described in 29 CFR 2510.3-102? (See instructions and DOL's	Voluntary Fig	fuciary Correction					****	
b	Program) Were there any nonexempt transactions with any party-in-interes			10a		V		·····	
***	reported on line 10a.)	***********		10b		~			
C	Was the plan covered by a fidelity bond?	**************	Sa alama di manana manana mpina m	10c		"			
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	s fidelity bond	d, that was caused	10d		<i>V</i>			
0		her persons	by an insurance	10e					
f	Has the plan failed to provide any benefit when due under the pla	n?				i		****	
	Did the plan have any participant loans? (If "Yes," enter amount a					60"			
	portion only participant leans; in ites, enter amount's	is or year-en	Q.)	10g		V			

10h

h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)

If 10h was enswered "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.....

From Medical Specialists Of Kentuckia 1.502.805.1974 Wed Jun 19 14:00:37 2019 EDT Page 5 of 5

Part	VI Pension Funding Compliance				
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sch. (Form 5500) and line 11a below)		88		Yes [
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?	1 302 c)f		Yes [
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)			<u></u>	
a	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver. Month	l enter Da		of the le Yea	
15	ou 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			
С	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			
9	Will the minimum funding amount reported on line 12d be met by the funding deadline?	l.	Yes	No	N
Part	VII Plan Terminations and Transfers of Assets				
13a	Has a resolution to terminate the plan been adopted in any plan year?		y 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	Mo No
c	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)	to			
1	3c(1) Name of plan(s): 13c(2)	EIN(s)	13	c(3) PNi