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

2018

This Form is Open to Public Inspection

A This return/report is or: a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) a namended return/report the first return/report a foreign plan a foreign plan year return/report (less than 12 months)			dentification Information								
A This return/report is for: a one-participant plan a foreign plan a short plan year return/report (less than 12 months) C C Check box if filing under: Form 5558 automatic extension DFVC program DFVC program peculiar destination DFVC program DFV	For calendar pl	an year 2018 or fisc	al plan year beginning 01/01/2	2018		and ending 12	2/31/20	18			
B This return/report is	A This return/	report is for:	X a single-employer plan								
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C Check box if filing under:	B This return/r	eport is	the first return/report	the	e final return/report						
Part II Basic Plan Information—enter all requested information 1a Name of plan AMMACA PHYSICAL THERAPY P.C. 401 K PROFIT SHARINS PLAN TRUST 1b Three-digit plan number (PN)		[an amended return/report	a s	short plan year return	/report (less than 12 m	months)				
Part II Basic Plan Information—enter all requested information	C Check box i	if filing under:	Form 5558	au	tomatic extension		DF\	/C program			
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18 Three-dight plan number (PN) 001	Part II B	asic Plan Infor	mation—enter all requested in	formation	on						
JAMAICA PHYSICAL THERAPY P.C 401 K PROFIT SHARING PLAN TRUST plan number (PN)							1b -	Three-digit			
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) JAMAICA PHYSICAL THERAPY PC 2c Sponsor's Lelephone number 718-297-36999 2d Business code (see instructions) 3b. Administrator's lame and address Same as Plan Sponsor. 3b. Administrator's EIN 3c Administrator's EIN 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year c Plan Name 5a Total number of participants at the end of the plan year c Number of participants with account belances as of the end of the plan year c Number of participants with account belances as of the end of the plan year d(2) Total number of active participants at the beginning of the plan year d(2) Total number of active participants at the beginning of the plan year b Number of participants with account belances as of the end of the plan year c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable ca	·						ļ ,	olan number	001		
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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) JAMAICA PHYSICAL THERAPY PC 2c Sponsor's telephone number 718-297-3699 2d Business code (see instructions) 621330 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number this plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year 5b 2 b Total number of participants at the end of the plan year 5b 2 c Number of participants with account balances as of the end of the plan year 5c 2 d(1) Total number of participants at the beginning of the plan year 5c 2 d(2) Total number of active participants at the beginning of the plan year 5c 2 d(2) Total number of participants with account balances as of the end of the plan year 5c 2 d(2) Total number of participants with account balances as of the end of the plan year 5c 2 d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 5c 5e 0 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, II applicable, a Schedule 8c or Schedule M5 completed and signed by an enrolled actuary, as well as the electronic version of this return/report, including, II applicable, a Schedule File with authorized velaid electronic signature. 607/24/2019 SAM OLAGUN-SAMUEL 618/64/64/64/64/64/64/64/64/64/64/64/64/64/	2a Plan snons	or's name (employe	er if for a single-employer plan)				2h [
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d(2) Total number of active participants at the end of the plan year					5c	:	2				
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	HERE Si	gnature of employ	er/plan sponsor		Date	Enter name of individ	ual sigr	ning as employe	er 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.) 									
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								Not determined (See instructions.)		
Par	t III Financial Information	1								
7	Plan Assets and Liabilities		(a) Beginning (of Year			(b) En	d of Year		
<u>a</u>	Total plan assets	7a	13	37998		133032				
b	Total plan liabilities	7b		0		0				
<u> </u>	Net plan assets (subtract line 7b from line 7a)	7c	1;	137998			133032			
	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	(a) Amount			(b) Total			
	Contributions received or receivable from: (1) Employers	8a(1)		478						
	(2) Participants	8a(2)		478						
	(3) Others (including rollovers)	8a(3)		0	_					
b	Other income (loss)	8b		-4595						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				-3639				
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		0						
е	Certain deemed and/or corrective distributions (see instructions)	8e		0						
f	Administrative service providers (salaries, fees, commissions)	8f		1327						
g	Other expenses	8g		0						
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				1327				
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i				-4		-4966		
j	Transfers to (from) the plan (see instructions)	8j		0						
Par	t IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 2G 2F 2E 2T 3D 2J 2K	feature co	des from the List of Pla	an Cha	racteri	stic Co	odes in the in	structions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Plan	n Chara	acteris	tic Cod	des in the ins	tructions:		
Par	Part V Compliance Questions									
10	During the plan year:		-		Yes	No		Amount		
Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)				10a		X				
b	b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)					Χ				
С	C Was the plan covered by a fidelity bond?				X			20000		
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?			10d		X				
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.)					X				
f	f Has the plan failed to provide any benefit when due under the plan?					Χ				
g	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)				X			29681		
h	h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)					X				
i	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									

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Part	VI Pension Funding Compliance						
11	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 ERISA?		f	Yes 🛛 N	Ю		
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)						
a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of granting the waiver							
lf y	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					
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?		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?) 	Yes X No				
c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)							
13c(1) Name of plan(s): 13c(2)				IN(s) 13c(3) PN(s)			