Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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**

For calcular plan year 2018 or fiscal plan year beginning	Part I	Annual Report	t identification information	1							
A This return/report is for: a one-participant plan a foreign plan a short plan year return/report (less than 12 months) C Check box if filing under: Form \$558 a utuomatic extension DFVC program DFVC pr	For calend	lar plan year 2018 or t	fiscal plan year beginning 01/01/2	2018		and ending 12	2/31/20)18			
B This return/report is	A This re	turn/report is for:	X a single-employer plan								
me tinst return/report me tinst return/report (less than 12 months)		·	a one-participant plan	_		,			,		
C Check box if filing under:	B This ret	urn/report is	the first return/report	the	final return/report						
Special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan Control Part II Basic Plan Information—enter all requested information 1c Effective date of plan Control Part II			an amended return/report	a sl	hort plan year return	/report (less than 12 m	onths)				
Part II Basic Plan Information—enter all requested information 1a Name of plan FLORIDA ENDOCRINOLOGY & DIABETES CENTER RETIREMENT PLAN 16 Effective date of plan FLORIDA ENDOCRINOLOGY & DIABETES CENTER RETIREMENT PLAN 16 Effective date of plan CPN) + 0001 17 Effective date of plan CPN) + 0001 18 Effect	C Check	box if filing under:	X Form 5558	au	tomatic extension		DF	VC program			
1a Name of plan FLORIDA ENDOCRINOLOGY & DIABETES CENTER RETIREMENT PLAN 1c Effective date of plan 1c Effective date of plan 00/10/1/2014 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) 4b-2301094 2c Sponsor's telephone number 727-623-9913 2d Business code (see instructions) 214 MESSENGER CIRCLE SAFETY HARBOR, FL 34895 3d Administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 727-623-9913 2d Business code (see instructions) 621111 3c Administrator's telephone number 1d Administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 4d PN 4d PN 4d PN 4d PN 5d Administrator's telephone number 5a Total number of participants at the beginning of the plan year 5b 4 C Number of participants at the end of the plan year 5d Administrator's telephone number 5d PN Administrato			special extension (enter desc	ription)							
1a Name of plan FLORIDA ENDOCRINOLOGY & DIABETES CENTER RETIREMENT PLAN 1c Effective date of plan 1c Effective date of plan 00/10/1/2014 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) 4b-2301094 2c Sponsor's telephone number 727-623-9913 2d Business code (see instructions) 214 MESSENGER CIRCLE SAFETY HARBOR, FL 34895 3d Administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 727-623-9913 2d Business code (see instructions) 621111 3c Administrator's telephone number 1d Administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 4d PN 4d PN 4d PN 4d PN 5d Administrator's telephone number 5a Total number of participants at the beginning of the plan year 5b 4 C Number of participants at the end of the plan year 5d Administrator's telephone number 5d PN Administrato	Part II	Basic Plan Info	ormation—enter all requested in	nformatio	n						
Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and 2P or foreign postal code (if foreign, see instructions) FLORIDA ENDOCRINOLOGY & DIABETES CENTER, LLC	1a Name		•				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) FLORIDA ENDOCRINOLOGY & DIABETES CENTER, LLC 2c Sponsor's Lelephone number 727-823-9913 2d Business code (see instructions) FLORIDA ENDOCRINOLOGY & DIABETES CENTER, LLC 314 MESSENGER CIRCLE SAFETY HARBOR, FL 34695 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 4 b Total number of participants at the end of the plan year 5c Number of participants with account balances as of the end of the plan year 5c 102 1 1 2 2 d(2) Total number of active participants at the beginning of the plan year 5c 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		•	DIABETES CENTER RETIREMEN	IT PLAN				plan number	001		
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) City or town, state or province, country, and 2IP or foreign postal code (if foreign, see instructions)							1c		•		
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) FLORIDA ENDOCRINOLOGY & DIABETES CENTER, LLC 22 Sponsor's telephone number 727-623-9913 23 Business code (see instructions) 621111 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 b Total number of participants at the head of the plan year 5b b Total number of participants with account balances as of the end of the plan year 5c c Number of participants with account balances as of the end of the plan year 5c d(1) Total number of active participants at the beginning of the plan year 5c d(2) Total number of participants with account balances as of the end of the plan year 5c d(2) Total number of participants with account balances as of the end of the plan year 5c d(2) Total number of participants with account balances as of the end of the plan year 5c d(3) Total number of participants with account balances as of the end of the plan year 5c d(4) Total number of participants who terminated employment during the plan year with accrued benefits that were less 1ban 100% vested 5c 1ban 100% vested 5c 1caution: 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 MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, including, II applicable, a Schedule 8c or Schedule MB c	2a Plan s	noncor's name (empl	over if for a single-employer plan)				2h	Employer Identi	fination Number		
### Sponsor's telephone number 1727-623-9913 ### 22	Mailing	g address (include roo	om, apt., suite no. and street, or P.0								
2314 MESSENGER CIRCLE SAFETY HARBOR, FL 34695 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 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. 2 Sponsor's name 2 Plan Name 5a Total number of participants at the beginning of the plan year 5 Total number of participants at the end of the plan year 6 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% wested 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% wested 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% wested 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% wested 7 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% wested 8 Or Schedule MB completed and signed by an enrolled actuary, 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 8 Signature of plan administrator 8 Date 8 Enter name of individual signing as plan administrator 9 Date 8 Enter name of individual signing as plan administrator	-			tal code	(if foreign, see instri	uctions)	2c	Sponsor's telep	hone number		
3a Plan administrator's name and address ⊠ Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 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 5a Total number of participants at the beginning of the plan year. 5 b Total number of participants at the end of the plan year. 5 c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d PN 5a Total number of active participants at the beginning of the plan year. 5 c 4 c Number of participants at the beginning of the plan year. 5 d(1) Total number of active participants at the beginning of the plan year. 5 d(2) 1 c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 5 c Under penalties of perjuny and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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. Signature of plan administrator Date Enter name of individual signing as plan administrator	FLORIDA EI	FLORIDA ENDOCRINOLOGY & DIABETES CENTER, LLC						•			
3a Plan administrator's name and address Same as Plan Sponsor. 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. 4 Sponsor's name 5 Plan Name 5 Total number of participants at the beginning of the plan year	0044 ME00					2d	Business code (see instructions)			
3a Plan administrator's name and address Same as Plan Sponsor. 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 5a Total number of participants at the beginning of the plan year					621111						
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 5a Total number of participants at the beginning of the plan year		, , ,									
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 5a Total number of participants at the beginning of the plan year	3a Plan a	administrator's name a	and address X Same, as Plan Spo	nsor.			3b	Administrator's	EIN		
4b EIN 4d PN Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d (1) Total number of participants at the beginning of the plan year (only defined contribution plans complete this item). 4d (2) Total number of participants at the beginning of the plan year (only defined contribution plans complete of active participants at the beginning of the plan year (only defined contribution plans complete this item). 4d (1) Total number of active participants at the beginning of the plan year (only defined contribution plans complete of active participants at the end of the plan year (only defined contribution plans complete of active participants at the end of the plan year (only defined contribution plans	Jan administrator s name and address A dame as i fair oponsor.										
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							3c Administrator's telephone number				
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											
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											
a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year							4b	EIN			
Total number of participants at the beginning of the plan year			onsor's name, Env, the plan name of	and the p	pian number nom m	e last return/report.	4d	PN			
b Total number of participants at the end of the plan year	C Plan N	Name									
b Total number of participants at the end of the plan year							-	_			
C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(1) Total number of active participants at the beginning of the plan year	_										
d(1) Total number of active participants at the beginning of the plan year											
d(2) Total number of active participants at the end of the plan year	comp	lete this item)							4		
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. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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. Date Enter name of individual signing as plan administrator SIGN HERE		·		-							
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, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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. Date Enter name of individual signing as plan administrator SIGN HERE							50(2)	1		
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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. Date Enter name of individual signing as plan administrator SIGN HERE	than	100% vested					ł		0		
SB or Schedule MB completed and signed by an enrolled actuary, 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 Filed with authorized/valid electronic signature. Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE											
SIGN HERE Filed with authorized/valid electronic signature. O9/13/2019 VENKATA BUDHARAJU Enter name of individual signing as plan administrator SIGN HERE	SB or Sche	SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and									
Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERF	SIGN				09/13/2019	VENKATA BUDHARA	JU				
HERE	HERE	Signature of plan	administrator		Date	Enter name of individ	idual signing as plan administrator				
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor											
	HERE	Signature of empl	oyer/plan sponsor		Date	Enter name of individ	ual sig	ning as employe	er or plan sponsor		

Form 5500-SF (2018) Page **2**

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)						X	es No		
b 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.)							X	es 🗌 No	
	If you answered "No" to either line 6a or line 6b, the plan cann							Ц	
С	If the plan is a defined benefit plan, is it covered under the PBGC in	nsurance p	rogram (see ERISA se	ection 4	021)?		Yes N	lo Not de	etermined
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	remium filing for this pl	lan yea	r			(See ins	tructions.)
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning of	of Year			(b) E	nd of Year	
а	Total plan assets	7a	26	62722				704	5
b	Total plan liabilities	7b		303				32	3
С	Net plan assets (subtract line 7b from line 7a)	7c	26	62419				672	2
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(I	o) Total	
а	Contributions received or receivable from:								
	(1) Employers	8a(1)			-				
	(2) Participants	8a(2)							
	(3) Others (including rollovers)	8a(3)		3315					
	Other income (loss)	8b		3313				331	5
d	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						331	<u> </u>
	to provide benefits)	8d	25	59012					
<u>e</u>	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						25901	2
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						-25569	7
<u>j</u>	Transfers to (from) the plan (see instructions)	8j							
Pai	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2K 2R 2T 3D	feature co	des from the List of Pla	an Cha	racteri	stic Co	des in the	instructions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	es from the List of Plan	n Chara	acterist	tic Cod	es in the ir	structions:	
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 contribu								
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)			10a		X			
b				IVa					
	reported on line 10a.)	`		10b		X			
С	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?			10d		X			
е	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	ne or all of	the benefits under	10e		X			
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		X			
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					

Form 5500-SF (2018)	Page 3 - 1

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)		В		Yes X No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a			
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA?				Yes X No
	(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	d enter t Day		of the lette _ Year _	er ruling
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			
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?		X Yes		lo
	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	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	B) PN(s)

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

	t Identification Information			
For calendar plan year 2018 or f	fiscal plan year beginning 01/01/20	18	and ending 12/31/2018	
A This return/report is for:	a single-employer plan		t multiemployer) (Filers checking this r information in accordance with the	
B This return/report is	a one-participant plan	a foreign plan		
,	the first return/report	the final return/report		
6 0	an amended return/report	a short plan year return/repor	rt (less than 12 months)	
C Check box if filing under:	X Form 5558 special extension (enter desc	automatic extension	☐ DFVC program	
Part II Basic Plan Info	ormation—enter all requested in			
1a Name of plan	ormation—enter all requested in	ilormation	1b Three-digit	
Florida Endocrinology & Diabetes	s Center Petirement Plan		plan numbe	r
Tionaa Enaconnology a Diabetes	Contai Nettiernent Flan		(PN) ▶	001
	1c Effective da 01/01/2014			
2a Plan sponsor's name (emple	loyer, if for a single-employer plan)		2b Employer Id	entification Number
Mailing address (include roo	om, apt., suite no. and street, or P.(O. Box)	(FIN) 46-23	
Florida Endocrinology & Diabetes	nce, country, and ZIP or foreign pos s Center, LLC	tal code (if foreign, see instructions	2C Sponsor's to	elephone number 27) 623-9913
				de (see instructions)
2314 Messenger Circle			621111	
0.67.11.1. =1.0700=				
Safety Harbor, FL 34695				
3a Plan administrator's name a	and address 🛛 Same as Plan Spo	onsor.	3b Administrato	ors EIN
			3C Administrate	r's telephone number
			OC Administrate	i s telephone number
4 If the name and/or EIN of the	he plan sponsor or the plan name h onsor's name, EIN, the plan name a	as changed since the last return/re	eport filed for 4b EIN	
a Sponsor's name	ones o hame, Ent, the plantiality	and the plan number from the last i	4d PN	
C Plan Name			12 / 11	
5a Total number of participants	s at the beginning of the plan year.	•••••••••••••••••••••••••••••••••••••••	5a	5
	s at the end of the plan year			4
C Number of participants with complete this item)	n account balances as of the end of	the plan year (only defined contrib	pution plans 5c	4
d(1) Total number of active pa	articipants at the beginning of the p	lan year	5d(1)	2
	articipants at the end of the plan ye			1
e Number of participants who than 100% vested	o terminated employment during the	e plan year with accrued benefits to	that were less 5e	0
Caution: A penalty for the late	or incomplete filing of this retur	n/report will be assessed unless	s reasonable cause is established) <u>.</u>
Under penalties of perjury and or SB or Schedule MB completed a belief, it is true, correct, and com	and signed by an enrolled actuary.	ctions, I declare that I have examir as well as the electronic version of	ned this return/report, including, if a f this return/report, and to the best o	oplicable, a Schedule f my knowledge and
SIGN		, Venka	ata Budharaju	
HERE Signature of plan a	administrator	(3/ 4) (9	er name of individual signing as plan	administrator
SIGN	aamming/atol	Date 11, NIN Eurei	a name or individual signing as plan	auministratul
HERE				
Signature of emplo		Date Enter	r name of individual signing as emp	loyer or plan sponsor

_				
Form	5500	QE.	/201	ופו

Р	age	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 either line 6a or line 6b, the plan cannot the plan is a defined benefit plan, is it covered under the PBGC in	an indepe and condi not use Fo	endent qualified public a itions.) orm 5500-SF and mus	account	ant (IC	PA) Form	X Yes No
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	premium filing for this p	lan yea	ır		. (See instructions.)
Pa	t III Financial Information						· · · · · · · · · · · · · · · · · · ·
7	Plan Assets and Liabilities		(a) Beginning	of Yea	•		(b) End of Year
<u>a</u>	Total plan assets	7a		2627	22		7045
<u>b</u>	Total plan liabilities	7b		3	03		323
<u> </u>	Net plan assets (subtract line 7b from line 7a)	7c		2624	19		6722
	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b) Total
а ——	Contributions received or receivable from: (1) Employers	8a(1)		-			
	(2) Participants	8a(2)				1000	
	(3) Others (including rollovers)	8a(3)					
<u>b</u>	Other income (loss)	8b		33	15		
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					3315
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		2590 ⁻	12		
	Certain deemed and/or corrective distributions (see instructions)	8e					
	Administrative service providers (salaries, fees, commissions)	8f				A): "	
	Other expenses	8g					
	Total expenses (add lines 8d, 8e, 8f, and 8g)						259012
	Net income (loss) (subtract line 8h from line 8c)						-255697
	Transfers to (from) the plan (see instructions)	<u>8j</u>				- 11/4	
_	t IV Plan Characteristics If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2K 2R 2T 3D If the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the compliance Questions						
10	During the plan year:				Yes	No	
	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	Fiduciary Correction	10a	103	X	Amount
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not	include transactions	10b		х	
C				10c		Х	
d		fidelity bo	nd, that was caused	10d		х	
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.)			10e		х	
f	Has the plan failed to provide any benefit when due under the pla			10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		х	
	If this is an individual account plan, was there a blackout period? (2520.101-3.)	(See instri	uctions and 29 CFR	10h		х	
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10	ne require	d notice or one of the	10i			

	5500-SF	/2040\
rorm	コンロローント	1701181

Page 3-	1
. 490 0	1 ' 1

Part	VI Pension Funding Compliance				-	
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sche (Form 5500) and line 11a below)	edule S	В		Yes	No.
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40					
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		f		Yes	X No
	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	enter Da		of the let Year		ng
<u>If</u>	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				
	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)						
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No		I/A
Part	VIII 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				0
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?					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) which assets or liabilities were transferred. (See instructions.)					
1		EIN(s)		13c	(3) PN	(s)