| - | rm 5500-SF | Short Form Annu | Short Form Annual Return/Report of Small Employe Benefit Plan | | | | | |
|--|---|---|--|----------------------------|-----------------------|---|--|--|
| | artment of the Treasury rnal Revenue Service | This form is required to be filed under sections 104 and 4065 of the Employee Re | | | | 2018 | | |
| Department of Labor Income Security Act of 1974 (ERISA), and sections 6057(b) and 6 Employee Benefits Security Administration Revenue Code (the Code). Pension Benefit Guaranty Corporation Revenue Code (the code). | | | | | Internal | This Form is Open to Public Inspection | | |
| | | | | | | | | |
| Part I | | Identification Information scal plan year beginning 01/01/2 | 018 | and ending 12 | 2/31/2018 | | | |
| | aal plan year 2010 01 h | \overline{X} a single-employer plan | | | | king this box must attach a | | |
| A This re | eturn/report is for: | | list of participating e | employer information in ac | | - | | |
| B This ret | is return/report is | | | | | | | |
| | the first return/report the final return/report an amended return/report as short plan year return/report (less than 12 months) | | | | | | | |
| C Check | box if filing under: | | | | _ | **** | | |
| • Oneck | box in hing under. | Form 5558 | automatic extension | | DFVC p | rogram | | |
| Part II | Basic Plan Info | special extension (enter descr rmation —enter all requested inf | , | | | | | |
| 1a Name | | Ination —enter all requested ini | ormation | | 1b Three | e-digit | | |
| | | OVASCULAR SURGERY, INC. RE | TIREMENT PLAN | | plan | number | | |
| | | | | | (PN) | tive date of plan | | |
| _ | | | | | | 01/01/1997 | | |
| Mailin | g address (include roo | yer, if for a single-employer plan) m, apt., suite no. and street, or P.O | | | 2b Empl (EIN) | oyer Identification Number 05-0492428 | | |
| | | e, country, and ZIP or foreign posta | al code (il foreign, see ins | structions) | 2c Spor | sor's telephone number 401-331-4175 | | |
| | | | | | | ness code (see instructions) | | |
| ONE RAND/ SUITE 414 | ALL SQUARE | | | | | 621111 | | |
| PROVIDEN | CE, RI 02904 | | | | | | | |
| 3a Plan a | administrator's name ar | nd address 🛛 Same as Plan Spor | isor. | | 3b Admi | nistrator's EIN | | |
| | | | | | 3c Admi | nistrator's telephone number | | |
| | | | | | | | | |
| 4 If the | name and/or FIN of the | e plan sponsor or the plan name ha | as changed since the last | return/report filed for | 4b EIN | | | |
| this p | lan, enter the plan spo | nsor's name, EIN, the plan name a | | | | | | |
| a Spons C Plan N | sor's name Name | | | | 4d PN | | | |
| | | | | | | | | |
| _ | | at the beginning of the plan year | | | 5a 5b | 1 | | |
| | | at the end of the plan yearat the end of the plan year account balances as of the end of the | | | 5b | 1 | | |
| comp | plete this item) | | | | 5c | 1 | | |
| d(1) ⊺ot | tal number of active pa | rticipants at the beginning of the pla | an year | | 5d(1) | | | |
| d(2) Total number of active participants at the end of the plan year | | | | | 5d(2) | 1 | | |
| 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 return her penalties set forth in the instruc | /report will be assesse | d unless reasonable cau | | | | |
| SB or Sch | | nd signed by an enrolled actuary, a | | | | | | |
| SIGN | Filed with authorized | /valid electronic signature. | 10/15/2019 | ANTHONY MOULTON | N, M.D. | | | |
| HERE Signature of plan administrator Date Enter name of individual signing as plan administrator | | | | | as plan administrator | | | |
| SIGN | | | | | | | | |
| HERE | Signature of emplo | | Date | Enter name of individ | ual signing | as employer or plan sponsor | | |
| For Paperw | vork Reduction Act Notic | e, see the Instructions for Form 5500 | -SF. | | | Form 5500-SF (2018) v.171027 | | |

| 6a | 6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) | | | | | | | | No |
|----|--|--------------|---------------------------------------|---------|---------|---------|---------------|-------------|-----|
| b | | | | | | | | | No |
| | under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) | | | | | | | | INO |
| С | If the plan is a defined benefit plan, is it covered under the PBGC in | | | | | | | Not determi | ned |
| • | If "Yes" is checked, enter the My PAA confirmation number from the | | | | | | | | |
| - | | | · · · · · · · · · · · · · · · · · · · | , | | | | | , |
| Pa | rt III Financial Information | | | | | | | | |
| 7 | Plan Assets and Liabilities | | (a) Beginning o | of Year | | | (b) En | d of Year | |
| a | Total plan assets | 7a | 11 | 10255 | | | | 81018 | |
| b | Total plan liabilities | 7b | | | | | | | |
| С | Net plan assets (subtract line 7b from line 7a) | 7c | 11 | 10255 | | | | 81018 | |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amoun | t | | | (b) | Total | |
| а | Contributions received or receivable from: | 0=(4) | | | | | | | |
| | (1) Employers | 8a(1) | | | - | | | | |
| | (2) Participants | 8a(2) | | | - | | | | |
| h | (3) Others (including rollovers) | 8a(3) | | -9222 | - | | | | |
| | b Other income (loss) | | | | | | 0000 | | |
| d | C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8c -9222 d Benefits paid (including direct rollovers and insurance premiums 6 -9222 | | | | | | | | |
| u | to provide benefits) | 8d | 2 | 20015 | | | | | |
| е | Certain deemed and/or corrective distributions (see instructions) | 8e | | | | | | | |
| f | | | | | | | | | |
| g | | | | | | | | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | | 20015 | | |
| i | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | | -29237 | |
| j | j Transfers to (from) the plan (see instructions) | | | | | | | | |
| Pa | rt IV Plan Characteristics | | I | | | | | | |
| 9a | | feature co | odes from the List of Pla | an Cha | racteri | stic Co | des in the in | structions: | |
| b | b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: | | | | | | | | |
| Pa | Part V Compliance Questions | | | | | | | | |
| 10 | During the plan year: | | | | Yes | No | | Amount | |
| a | 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 | | | |
| k | Were there any nonexempt transactions with any party-in-interest reported on line 10a.) | | | 10b | | Х | | | |
| C | Was the plan covered by a fidelity bond? | ······ | | 10c | X | | | 20000 | |
| C | Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty? | fidelity bo | nd, that was caused | 10d | | х | | | |
| e | Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.). | ne or all of | the benefits under | 10e | | X | | | |

Х

Х

Х

10f

10g

10h

10i

f Has the plan failed to provide any benefit when due under the plan?

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

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

i

2520.101-3.<u>)</u>_____

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

Page **3-** 1

| Part | VI | Pension Funding Compliance | | | | | | |
|------|-------|---|------------------|-----------------|-------|-------------|---------|------|
| 11 | | nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and rm 5500) and line 11a below) | | | B | | Yes | No |
| 11a | Ent | er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 | | 11a | | | | |
| 12 | ERI | his a defined contribution plan subject to the minimum funding requirements of section 412 of the C SA? "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) | | n 302 o | f | [| Yes | X No |
| а | | waiver of the minimum funding standard for a prior year is being amortized in this plan year, see institution the waiver. | | l enter _ Da | | e of the le | | ing |
| lf | you d | completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line | 13. | | - | | | |
| b | Ente | r the minimum required contribution for this plan year | | 12b | | | | |
| С | Ente | r the amount contributed by the employer to the plan for this plan year | | 12c | | | | |
| d | | tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the ative amount) | | 12d | | | | |
| е | Will | the minimum funding amount reported on line 12d be met by the funding deadline? | | | Yes | No | | N/A |
| Part | VII | Plan Terminations and Transfers of Assets | | | | | | |
| 13a | Has | a resolution to terminate the plan been adopted in any plan year? | | | Ye | s X | No | |
| | lf "Y | es," enter the amount of any plan assets that reverted to the employer this year | | 13a | | | | |
| b | | re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brou trol of the PBGC? | ght under the | | | Yes | × N | 0 |
| С | | luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident ch assets or liabilities were transferred. (See instructions.) | tify the plan(s) | to | | | | |
| 1 | 3c(1 |) Name of plan(s): | 13c(2) | EIN(s) | | 130 | :(3) PN | l(s) |
| | | | | | | | | |

| Department of the Treasury | | ual Return/Repo Benefit Plan | | - | | 1210-0 |
|--|--|--|---|---|--|--|
| Internal Revenue Service | This form is required to be f | iled under sections 104 and | i 4065 of the Employee i | Retirement | | 2018 |
| Department of Labor Employee Benefits Security Administration | Income Security Act of 197 | 74 (ERISA), and sections 6 Revenue Code (the Co | 057(b) and 6058(a) of th de). | ié Internal | | orm is Open t |
| Pension Benefit Guatanty Corporation | Complete all entries in | n accordance with the ins | | 5500-SE | Publ | ic inspection |
| Part Manual Repor | t Identification Informatio | n | | JJJU-01. | | |
| or calendar plan year 2018 or | fiscal plan year beginning | 01/01/2018 | and ending | 12/3 | 31/2018 | |
| This return/report is for: | 🗶 a single-employer plan | a multiple-employer Ilst of participating e | plan (not multlemployer) employer information in a |) (Filers check accordance w | ing this bo ith the form | x must attach a |
| | a one-participant plan | 🗌 e foreign plan | | | | |
| This return/report is | the first return/report | the final return/repor | + . | | | |
| | an amended return/report | | urn/report (less than 12 r | nonthe) | | |
| Check box if filing under; | | - | | | | |
| Griebic bez ir ning under, | ⊠ Form 5558 | automatic extension | I | U DFVC ρι | rogram | |
| | special extension (enter dea | | | | • | |
| | ormationenter all requested i | Information | | | | |
| a Name of plan SEACOAST THORACTI | C & CARDIOVASCULAR S | IDCEDY THE DEF | 17 T) TI BATING TO YOU AND | 1b Three | | |
| 0=0011D1 10000101. | C & CHUDIOANDCOTHE 3 | ORGERI, INC. RET | IREMENT PLAN | (PN) | number • | 001 |
| | | | | 1c Effect | | plan 7 |
| a Plan sponsor's name (empl | oyer, if for a single-employer plan) |) | | | | , Ication Numbe |
| Mailing address (include roc | om, apt., suite no. and street, or P ce, country, and ZIP or foreign po | () Box) | | | 05-049 | |
| SEACOAST THORACI | C & CARDIOVASCULAR S | URGERY, TNC. | scuctions) | | | hone number |
| | | | | | -331-41 | |
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| ONE RANDALL SQUAR | RE | | | 2d Busin | ess code (: | see instruction |
| SUITE 414 | | | | 2d Busin | ess code (: | see instruction |
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| | Form 5500-SF (2018) | | Page 2 | |
|----|---|---|---|--|
| 6a | Were all of the plan's assets during the plan year invested in elig | ible assets? | (See instructions.) | X Yes M |
| b | Are you claiming a waiver of the annual examination and report o under 29 CFR 2520.104-487 (See instructions on waiver eligibility | f an indeper y and condit | ident qualified public accountant (IQP ions.) | A)X Yes ∏ M |
| _ | If you answered "No" to either line 6a or line 6b, the plan car | | | |
| G | If the plan is a defined benefit plan, is it covered under the PBGC If "Yes" is checked, enter the My PAA confirmation number from t | | | |
| | Financial Information | | | |
| 7 | Plan Assets and Liabilities | | (a) Beginning of Year | (b) End of Year |
| a | Total plan assets | 7a | 110,255 | 81,0 |
| | Total plan llabilities | | | |
| | Net plan assets (subtract line 7b from line 7a) | | 110,255 | 81,0 |
| } | Income, Expenses, and Transfers for this Plan Year | CC / ACTOR / ACTOR In the second Contactor | (a) Amount | (b) Total |
| a | Contributions received or receivable from: (1) Employers | | | |
| | (2) Participants | 8a(2) | | |
| | (3) Others (including rollovers) | | | a a contraction and the second se |
| b | Other income (loss) | . 8b | -9,222 | |
| С | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | . 8c | | -9,2 |
| | Benefits pald (Including direct rollovers and insurance premiums to provide benefite) | | 20,015 | |
| e | Certain deemed and/or corrective distributions (see instructions) | . 8e | | |
| f_ | Administrative service providers (salaries, fees, commissions) | 8f | | |
| g | Other expenses | . 6g | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | . Bh | | 20,0 |
| F | Net income (loss) (subtract line 8h from line 8c) | . 81 | | -29,2 |
| j | Transfers to (from) the plan (see Instructions) | - 8i | | |
| 錒 | Plan Characteristics | | | anan mananan kanan kana kanan ka Kanan kanan kana |
| | If the plan provides pension benefits, enter the applicable pension 2A_2E_3D | n feature co | des from the List of Plan Characteristic | c Codes In the instructions: |
| b | If the plan provides welfare benefits, enter the applicable welfare | feature code | es from the List of Plan Characteristic | Codes in the instructions: |

| 10 | During the plan year: | Yes | No | Amount | |
|-----|--|-------|----|--------|--|
| ä | 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 | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | 10b | | x | |
| _ C | Was the plan covered by a fidelity bond? | 10c | х | | 20,000 |
| 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 | | х | ······································ |
| e | | 10e | | x | |
| f | Has the plan failed to provide any benefit when due under the plan? | 10f | | х | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) | 10a | | х | |
| h | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | 10h | | х | |
| 1 | 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 | 10i - | | | |