#### 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

2018

This Form is Open to Public Inspection

Part I	Annual Report Id	dentification Information								
For calenda	ar plan year 2018 or fisc	cal plan year beginning 07/01/201	8	and ending 06/30/2019						
A This retu	urn/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>B</b> This retu	urn/report is:	the first return/report								
		an amended return/report		a short plan year return/report (less than 12 m	onths)	)				
C If the pla	an is a collectively-barga	ained plan, check here				<b>•</b> [				
<b>D</b> Check b	oox if filing under:	X Form 5558		automatic extension	the	e DFVC program				
		special extension (enter descri	iption)							
Part II	Part II Basic Plan Information—enter all requested information									
1a Name o	of plan	EAST CENTER AT THE VILLAGES			1b	Three-digit plan number (PN) ▶	501			
					1c	Effective date of plants 12/01/2006	an			
Mailing City or	address (include room town, state or province	er, if for a single-employer plan) , apt., suite no. and street, or P.O. , country, and ZIP or foreign postal	l code	(if foreign, see instructions)	2b	Employer Identifica Number (EIN) 59-3522082	ition			
LAKE MEDI	ICAL IMAGING & BREA	AST CENTER AT THE VILLAGES,		2c	Plan Sponsor's tele number 352-365-2857	ephone				
SUITE 112 734 N 3RI			N 3RD	DICAL IMAGING I ST G, FL 34748-5287		Business code (see instructions) 621399	Э			

#### 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	01/07/2020 Date	CHUCK BENTLY  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/07/2020	CHUCK BENTLY
SIGN HERE	Signature of employer/plan sponsor  Signature of DFE	Date	Enter name of individual signing as employer or plan sponsor  Enter name of individual signing as DFE

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

Form 5500 (2018) v. 171027

Form 5500 (2018) Page 2 3a Plan administrator's name and address X Same as Plan Sponsor **3b** Administrator's EIN

		3c Administrato number	r's telephone	
4 a c	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return enter the plan sponsor's name, EIN, the plan name and the plan number from the last return Sponsor's name Plan Name	4b EIN 4d PN		
5	Total number of participants at the beginning of the plan year		5	193
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans 6a(2), 6b, 6c, and 6d).	complete only lines 6a(1),		
a(	(1) Total number of active participants at the beginning of the plan year		6a(1)	193
a(	(2) Total number of active participants at the end of the plan year		6a(2)	203
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	203
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>		6f	
g	Number of participants with account balances as of the end of the plan year (only defined complete this item)		6g	
	Number of participants who terminated employment during the plan year with accrued benefices than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plan provides pension benefits, enter the applicable pension feature codes from the Lis	, ,	7	
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List 4B 4D 4E 4F 4H	t of Plan Characteristics Codes	s in the instruction	
<b>у</b> а	Plan funding arrangement (check all that apply)         9b         Plan ber           (1)	nefit arrangement (check all that X Insurance Code section 412(e)(3) in Trust X General assets of the sp	insurance contrac	ts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, w	here indicated, enter the numb	er attached. (See	e instructions)
а	A Pension Schedules  (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial  (5)	I Schedules  H (Financial Inform  I (Financial Inform  A (Insurance Inform  C (Service Provide  D (DFE/Participatii	nation – Small Pla mation) er Information)	
	Information) - signed by the plan actuary (6)	G (Financial Trans	saction Schedules	)

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

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 plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)							
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt 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 Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)  Receipt Confirmation Code							

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

pursuant to ERISA section 103(a)(2).							Inis Form is Open to Public Inspection		
For calendar plan year 20	18 or fiscal pla	an year beginning 07/01/2018		and en	nding 06/3	0/2019	•		
A Name of plan LAKE MEDICAL IMAGINO	G & BREAST	CENTER AT THE VILLAGES, V	VELFARE PLAN		e-digit number (PN	N) <b>•</b>	501		
C Plan sponsor's name a		ne 2a of Form 5500 CENTER AT THE VILLAGES, L	LC		oyer Identifica 3522082	ation Number	(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 persons covered a			Policy or o	contract year		
(6) LIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To		
36-0883760	68381	LTD 126315	127	7	07/01/2018	8	06/30/2019		
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in		
(a) Total a		<b>(b)</b> To	otal amount	of fees paid					
					0				
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).					
		and address of the agent, broke		-	ions or fees	were paid			
LASSITER WARE			MAITLAND CENTER PA LAND, FL 32751	RKWAY					
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code		
	5806						3		
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
	(a) Hame	and address of the agent, went	., e. ee. percentee			were para			
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code		

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (e) Organization spaid  (b) Amount of sales and base commissions paid  (e) Organization code  (f) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions or fees were paid  (h) Amount of sales and base commissions paid  (h) Amount of sales and base commissions or fees were paid			
		From and other constitutions and	(-)
			Organization
commissions paid	(C) Amount	(a) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	
	(c) Amount	(d) Purpose	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase			(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of									
		this report.									
		ent value of plan's interest under this contract in the general account at year			4						
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5						
6		racts 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 co			6d						
		retention of the contract or policy, enter amount.			<b>-</b>						
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)							
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee							
		(3) ☐ guaranteed investment (4) ☐ other ▶									
		<del>-</del>									
	b	Balance at the end of the previous year			7b						
	С	Additions: (1) Contributions deposited during the year									
		(2) Dividends and credits	7c(2)								
		(3) Interest credited during the year	. 7c(3)								
		(4) Transferred from separate account	7c(4)								
		(5) Other (specify below)	. 7c(5)								
		•									
	_	(6)Total additions			7c(6)						
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d						
		Deductions:	7-(4)								
		(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) 7e(4)								
		(4) Other (specify below)	. /e(4)								
		•									
		(5) Total deductions			7e(5)						
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f						

P	art	Ш	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 cont	racts are expe	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance	
	e	=	emporary disability (accident and sickness)	f X Long-term disabili	_	Supplemental unem	ployment	h Prescription drug	
		=	op loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	pioyillolli	I Indemnity contract	
	' [ 			I I I I I I I I I I I I I I I I I I I	κ	FFO contract		I I Indemnity contract	
	m		ther (specify)						
Ω.		orion	ce-rated contracts:						
			iums: (1) Amount received		02/1)		0		
	а		ncrease (decrease) in amount due but unpaid		9a(1) 9a(2)		0		
			ncrease (decrease) in unearned premium res						
			Earned ((1) + (2) - (3))				. 9a(4)		C
	b	. ,	efit charges (1) Claims paid				1 55(1)		
			ncrease (decrease) in claim reserves						
		(3) li	ncurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)		
		(4) (	Claims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes		9C(1)(E)				
			(F) Charges for risks or other contingencies.		9c(1)(F)				
			(G) Other retention charges				9c(1)(H)		_
			(H) Total retention  Dividends or retroactive rate refunds. (These					<u>'</u>	_
	a			_	_				
	d		tus of policyholder reserves at end of year: (1 Claim reserves				. 9d(1) . 9d(2)		_
		` '	Other reserves				9d(3)		_
	е	` '	dends or retroactive rate refunds due. (Do n						_
10	_		perience-rated contracts:			,	1		
	а		al premiums or subscription charges paid to o	arrier			. 10a	2322	25
	b	If th	e carrier, service, or other organization incur	red any specific costs in c	onnection witl	h the acquisition or			
		rete	ntion of the contract or policy, other than repnature of costs.	, ,		•	. 10b		
	•	,							
Pa	art	ΙV	Provision of Information						
11	Die	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	А?П	Yes	X No	
			nswer to line 11 is "Yes," specify the informat		2.0 001104410		-		_
14	11 (	ıı <del>c</del> di	iswer to line in is nes, specify the informat	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.

OMB No. 1210-0110

		•	ERISA section 103(a)(2)		lion	This Fo	m is Open to Public Inspection			
For calendar plan year 20	18 or fiscal pla	an year beginning 07/01/2018		and en	nding 06/30	)/2019				
A Name of plan LAKE MEDICAL IMAGING	G & BREAST	CENTER AT THE VILLAGES, V	VELFARE PLAN		e-digit number (PN	) •	501			
	G & BREAST	CENTER AT THE VILLAGES, L		59-	oyer Identifica 3522082					
		erning Insurance Contract  A. Individual contracts grouped								
1 Coverage Information:										
(a) Name of insurance ca RELIANCE STANDARD	rrier		(A) Associated	and an af	I	Dalianas				
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	From	r (EIN)  ormation for each contract ule A.  contract year  (g) To  06/30/2019			
36-0883760	68381	G 164172	150	•	07/01/2018		06/30/2019			
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	orokers, and	other persons in			
(a) Total a		<b>(b)</b> To	otal amount o	f fees paid						
``		` '		·	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 v	were paid				
LASSITER WARE			MAITLAND CENTER PA LAND, FL 32751	RKWAY						
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid						
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code			
	3512						3			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees v	were paid				
(b) Amount of sales ar			ees and other commissio				_			
commissions pa	id	(c) Amount		(d) Purpose	e		(e) Organization code			

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (e) Organization spaid  (b) Amount of sales and base commissions paid  (e) Organization code  (f) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions or fees were paid  (h) Amount of sales and base commissions paid  (h) Amount of sales and base commissions or fees were paid			
		From and other constitutions and	(-)
			Organization
commissions paid	(C) Amount	(a) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	
	(c) Amount	(d) Purpose	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase			(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of									
		this report.									
		ent value of plan's interest under this contract in the general account at year			4						
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5						
6		racts 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 co			6d						
		retention of the contract or policy, enter amount.			<b>-</b>						
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)							
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee							
		(3) ☐ guaranteed investment (4) ☐ other ▶									
		<del>-</del>									
	b	Balance at the end of the previous year			7b						
	С	Additions: (1) Contributions deposited during the year									
		(2) Dividends and credits	7c(2)								
		(3) Interest credited during the year	. 7c(3)								
		(4) Transferred from separate account	7c(4)								
		(5) Other (specify below)	. 7c(5)								
		•									
	_	(6)Total additions			7c(6)						
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d						
		Deductions:	7-(4)								
		(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) 7e(4)								
		(4) Other (specify below)	. /e(4)								
		•									
		(5) Total deductions			7e(5)						
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f						

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ting p	o of e	ses if so	uch con	tracts are	expe	erience-rated as a ur	it. Where o	ontract	s cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)	1										
	а	Не	ealth (other than dental or vision)	b	De	ental			С	Vision		d	Life insurance	
	e	Τe	emporary disability (accident and sickness)	f 🗏	- Lo	ng-term	n disabil	lity	g	Supplemental unen	nployment	h∏	Prescription drug	
	i Ē	_	op loss (large deductible)	ιĖ	_	ЛО cont		,		PPO contract	. ,	- =	Indemnity contract	
	<u> </u>	_		, _	J	VIO 00111	liuot		., _	1 1 0 contract		•п	macminity contract	
	m		ther (specify)											
a	Evno	rion	ce-rated contracts:											
,	•		niums: (1) Amount received					. 9a(1	`					
			ncrease (decrease) in amount due but unpaid					•	_					
			ncrease (decrease) in unearned premium res						•					
		` '	Earned ((1) + (2) - (3))								9a(4)			_
		. ,	efit charges (1) Claims paid								, ,			
		(2) I	ncrease (decrease) in claim reserves											
		(3) I	ncurred claims (add (1) and (2))								9b(3)			
		(4) (	Claims charged								9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accru	ual basi	is)							
			(A) Commissions											
			(B) Administrative service or other fees					0 (4)/						
			(C) Other specific acquisition costs					0.7417						
			(D) Other expenses					0-/41/	_					
			(E) Taxes											
			(F) Charges for risks or other contingencies. (G) Other retention charges					0-/41/						
			(H) Total retention(H)						-		9c(1)(H	)		
			Dividends or retroactive rate refunds. (These			_	_		_			,		
	d		tus of policyholder reserves at end of year: (1			<u> </u>								_
	u		Claim reserves											
		` '	Other reserves											
	е	` '	dends or retroactive rate refunds due. (Do n											
10			perience-rated contracts:							,	•			
	а	Tota	al premiums or subscription charges paid to o	carrier	r						10a		468	34
	_	rete	e carrier, service, or other organization incur- ntion of the contract or policy, other than rep- nature of costs.								10b			
	Spec	rete	ntion of the contract or policy, other than replanture of costs.  Provision of Information	orted	in Pa	art I, lind	e 2 abo	ve, report	amo.	ount				
11	Did	the	insurance company fail to provide any inform	nation	nec	essary	to com	olete Sche	edule	A?	Yes	X No	0	•
			nswer to line 11 is "Yes," specify the informat				-	2.2 00.10						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).						rm is Open to Public Inspection		
For calendar plan year 20	18 or fiscal pla	an year beginning 07/01/2018		and en	ding 06/30	/2019	•	
A Name of plan LAKE MEDICAL IMAGINO	G & BREAST	CENTER AT THE VILLAGES, V	VELFARE PLAN		e-digit number (PN)	<u> </u>	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)		
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 nu persons covered a			Policy or o	contract year	
(b) EIN	code	identification number	policy or contrac		(f) F	From	<b>(g)</b> To	
36-0883760	68381	GL 154290	1968775	j	07/01/2018		06/30/2019	
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. L	st in line 3	the agents, b	rokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
	8775 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).				
		and address of the agent, broke	·		ions or fees v	vere paid		
LASSITER WARE			MAITLAND CENTER PA LAND, FL 32751	RKWAY				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code	
	8775						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees v	vere paid		
	(4)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
(b) Amount of sales ar	nd base	Ę	ees and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated a	as a unit for purposes of			
		this report.							
		ent value of plan's interest under this contract in the general account at year			4				
-		rrent value of plan's interest under this contract in separate accounts at year end							
6		racts 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 co			6d				
		retention of the contract or policy, enter amount.			<b>-</b>				
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)					
	а	Type of contract: (1) deposit administration (2) immediate participation guarantee							
		(3) guaranteed investment (4) other							
		<del>-</del>							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year							
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	. 7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	. 7c(5)						
		•							
	_	(6)Total additions			7c(6)				
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d				
		Deductions:	7-(4)						
		(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) 7e(4)						
		(4) Other (specify below)	. /e(4)						
		•							
		(5) Total deductions			7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f				

P	art II		e Benefit Contract Inform										
		the infor	han one contract covers the same mation may be combined for repor es, the entire group of such individe	ting p	urpo	ses if such o	contra	icts are	expe	rience-rated as a unit	. Where c	ontrac	ts cover individual
8	Benef	fit and contrac	t type (check all applicable boxes	)									
	а	a  ☐ Health (other than dental or vision)								d X	Life insurance		
	е 🗍	Temporary of	lisability (accident and sickness)	f	= Lo	ng-term disa	ability	g	3 🗍	Supplemental unemp	oloyment	h∏	Prescription drug
	iΠ		rge deductible)	ιĒ	_	//O contract	-			PPO contract	-	ıĦ	Indemnity contract
	m∏	Other (speci		, <sub>L</sub>	」			-	`Ш			- Ш	machining community
	□	Other (speci	iy) •										
9	Evner	ience-rated co	ontracts:										
•	•		Amount received					9a(1)					
		` ,	ecrease) in amount due but unpai				_	9a(2)					
	,	,	lecrease) in unearned premium re				_	9a(3)					
			) + (2) - (3))					-			9a(4)		
	b E	Benefit charge	es (1) Claims paid					9b(1)			•		
	(2	2) Increase (d	lecrease) in claim reserves					9b(2)					
	(;	3) Incurred cla	aims (add <b>(1)</b> and <b>(2)</b> )								9b(3)		
	(4	4) Claims cha	rged								9b(4)		
	C F	Remainder of	premium: (1) Retention charges (	on an	accr	ual basis)	_		-				
		` '	issions					9c(1)(A					
		` '	istrative service or other fees					9c(1)(B					
		, ,	specific acquisition costs				_	9c(1)(C 9c(1)(D	_				
		` ,	expenses				_	9c(1)(E	_				
		` '	es for risks or other contingencies.				_	9c(1)(F	_				
							_	9c(1)(G	_				
	(G) Other retention charges					9c(1)(H	)						
	(	` '	or retroactive rate refunds. (These					_				1	
			yholder reserves at end of year: (			_					9d(1)		
		•	rves	•		•					9d(2)		
	,	,	rves								9d(3)		
	<b>e</b> [	Dividends or r	etroactive rate refunds due. (Do r	ot inc	lude	amount ent	ered i	in line 90	(2).	)	9e		
10	Non	experience-ra	ted contracts:										
	a T	Total premium	ns or subscription charges paid to	carrie	r						10a		87752
	r	etention of th	service, or other organization incur e contract or policy, other than rep								10b		
		etention of th		ortea	in Pa	art I, line 2 a	ibove	, героп а	amo	unt	100		
	art IV		sion of Information company fail to provide any inforr	natior	n nec	essarv to co	mple	te Sched	lule	A? П	Yes	X N	0
							pic					Ц .,	-
12	it the	e answer to lir	ne 11 is "Yes," specify the informa	uon n	ot pro	oviaea. 🕨							

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

pursuant to ERISA section 103(a			RISA section 103(a)(2).	Tills For	Inspection
For calendar plan year 20	18 or fiscal pla	n year beginning 07/01/2018	and er	nding 06/30/2019	
A Name of plan LAKE MEDICAL IMAGING	G & BREAST (	CENTER AT THE VILLAGES, WEI	EADE DLAN	ee-digit n number (PN)	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)
		rning Insurance Contract  A. Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca RELIANCE STANDARD	rrier				
ALA FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
36-0883760	68381	136-003315	203	12/01/2018	06/30/2019
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and c	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees page 1				otal amount of fees paid	
		4338			0
3 Persons receiving com	missions and f	fees. (Complete as many entries a	s needed to report all persons).		
	(a) Name a	and address of the agent, broker, o		sions or fees were paid	
LASSITER-WARE INC		PO BOX LEESBU	490690 IRG, FL 34749-0690		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code
	4338				3
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	sions or fees were paid	
LASSITER-WARE INSURA		2701 MA	NTLAND CENTER PARKWAY ND, FL 32751		
(b) Amount of sales ar	nd hase	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code
					3
Fan Barramanala Bardan da	n Ast Nation	and the Instructions for Form FF	200	0-1-	dula A (Form FF00) 2018

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated a	as a unit for purposes of			
		this report.							
		ent value of plan's interest under this contract in the general account at year			4				
-		rrent value of plan's interest under this contract in separate accounts at year end							
6		racts 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 co			6d				
		retention of the contract or policy, enter amount.			<b>-</b>				
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)					
	а	Type of contract: (1) deposit administration (2) immediate participation guarantee							
		(3) guaranteed investment (4) other							
		<del>-</del>							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year							
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	. 7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	. 7c(5)						
		•							
	_	(6)Total additions			7c(6)				
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d				
		Deductions:	7-(4)						
		(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) 7e(4)						
		(4) Other (specify below)	. /e(4)						
		•							
		(5) Total deductions			7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f				

P	art	Ш	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 individ					
Ω	Don	ofit o	and contract type (check all applicable boxes)		arrier may be	troated do a drift for p	aiposco oi t	inio repert.
O	F	_		_	<u> </u>	1		a 🗆
	a [		ealth (other than dental or vision)	<b>b</b> X Dental	_	Vision		d ∐ Life insurance
	е	Te	emporary disability (accident and sickness)	f Long-term disability	ty <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription drug
	i	St	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	O	ther (specify)					
	,	L						
9	Ехр	erien	ce-rated contracts:					
			niums: (1) Amount received		9a(1)			
		(2) li	ncrease (decrease) in amount due but unpai	b				
		(3) li	ncrease (decrease) in unearned premium res	serve	9a(3)			
		(4) E	Earned ((1) + (2) - (3))				9a(4)	
	b	Ben	nefit charges (1) Claims paid		9b(1)			
		(2) lı	ncrease (decrease) in claim reserves		9b(2)			
		(3) li	ncurred claims (add (1) and (2))				. 9b(3)	
		` '	Claims charged				9b(4)	
	С	Ren	nainder of premium: (1) Retention charges (	n an accrual basis)				
			(A) Commissions		9c(1)(A)			
			(B) Administrative service or other fees					
			(C) Other specific acquisition costs					
			(D) Other expenses					
			(E) Taxes		9C(1)(E)			
			(F) Charges for risks or other contingencies.		9C(1)(F)			
			(G) Other retention charges				0-(4)(11)	A .
			(H) Total retention				9c(1)(H)	)
			Dividends or retroactive rate refunds. (These	<b>—</b>				
	d		tus of policyholder reserves at end of year: (1					
		` '	Claim reserves				9d(2)	
	_	` '	Other reserves				9d(3)	
10	<u>e</u>		dends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2).	.)	9e	
10	_		perience-rated contracts:	20 44 4			100	40400
	a		al premiums or subscription charges paid to c				10a	194898
	b		e carrier, service, or other organization incur ention of the contract or policy, other than rep	, ,		•	10b	
	Spe		nature of costs.	Sitted in Fait 1, line 2 abov	c, report amo	, unit		
	-	_						
P	art	IV	Provision of Information					
					lata Calcodol	Λ2 Π	Voc	X No
			insurance company fail to provide any inform		ete Schedule	A /	Yes	X No
12	If t	the ar	nswer to line 11 is "Yes," specify the informat	on not provided.				



13 17 Citizens Boulevard • Leesburg, FL 34748

Department of Treasury

Internal Revenue Service Center

Ogden, UT 84201-2045

**NEOPOST** 

FIRST-CLASS MAIL



# Form **5558** (Rev. September 2018)

(1101: Coptomber 2010)

Department of the Treasury Internal Revenue Service

# Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

► Go to www.irs.gov/form5558 for the latest information.

OMB No. 1545-0212

File With IRS Only

	ган	Identification				,47	
341 Oak Terrace Drive Suite 112 City or town, state, and ZIP code Leesburg Ft. 34748  C Plan name Plan mumber Plan mumber Plan mumber Plan mumber Plan mumber Plan mumber MM DD  Lake Medical Tasging & Breast Center at the Villages, Welfare Pls 501 06 30  Partill Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  2 I request an extension of time until 04 / 15 / '2020 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.  3 I request an extension of time until 04 / 15 / 2020 to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions).  A policial security number (SSN) (6 digits XXXX			B Filer's identifyIng number (see instructions) Employer identification number (EIN)(9 digits XX-XXXXXXX)				
City or town, state, and ZIP code  Leesburg  Plan name  Plan plan plan plan number  Reducal Imaging 6 Breast Center at the Villages, Welfare Pls  Total Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  I request an extension of time until 04 / 15 / 2020 to file Form 5500 series (see instructions).  Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions).  Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.  The application is automatically approved to the date shown on line 2 and/or line 3 (above) if (a) the Form 5508 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.  Part III Extension of Time To File Form 5330 (see instructions)  I request an extension of time until / to file Form 5330.  A I request an extension of time until / to file Form 5330.  Extension of Time To File Form 5330 (see instructions)  Letter the Code section(s) imposing the tax	١	Number, street, and room or suite no. (If a P.O. box, see instructions)	59-352208	12		<u> </u>	
Plan name Plan pear endinumber  Rake Medical Imaging & Breast Center at the Villages, Welfare Pla 501 06 30  Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  I request an extension of time until 04 / 15 / 2020 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.  The application is automatically approved to the date shown on line 2 and/or line 3 (above) if. (a) the Form 5558 is filed on the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.  Part III Extension of Time To File Form 5330 (see instructions)  4 I request an extension of time until / / to file Form 5330.  a Enter the Code section(s) imposing the tax	3	341 Oak Terrace Drive Suite 112	Social securi	ty number (SSN)	(9 digits XXX-XX	-XXXX)	
Plan name Plan number Plan number Plan number Plan number Plan number Plan proper plan pro	(	City or town, state, and ZIP code					
Lake Medical Imaging & Breast Center at the Villages, Welfare Pls 501 06 30  Part III Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  2 I request an extension of time until 04 / 15 / '2020 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.  The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed on the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.  Part III Extension of Time To File Form 5330 (see instructions)  4 I request an extension of time until / / to file Form 5330. You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.  a Enter the Code section(s) imposing the tax	1	Leesburg FL 34748	•				
Lake Medical Imaging & Breast Center at the Villages, Welfare Pls 501 06 30  Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  2 I request an extension of time until 04 / 15 / 2020 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.  The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed or the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.  Part III Extension of Time To File Form 5330 (see instructions)  4 I request an extension of time until / / to file Form 5330. The part of time until / / to file Form 5330.  a Enter the Code section(s) imposing the tax	;	Plan name	Plan	Pla	n year endin	g	
Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA  1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the in Part 1, C above.  2 I request an extension of time until 04 / 15 / 2020 to file Form 5500 series (see instructions).  Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA (see instructions).  Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.  The application is automatically approved to the date shown on line 2 and/or line 3 (above) if. (a) the Form 5558 is filed on the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.  Part III Extension of Time To File Form 5330 (see instructions)  4 I request an extension of time until / to file Form 5330. You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.  a Enter the Code section(s) imposing the tax	_	Figit fighte	number	MM	DD	YYYY	
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4 I request an extension of time until / / to file Form 5330.  You may be approved for up to a 6 month extension to file Form 5330; after the normal due date of Form 5330.  a Enter the Code section(s) imposing the tax		the normal due date of Form 5500 series, and/or Form 8955-SSA for which this	s extension is requ				
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.  a Enter the Code section(s) imposing the tax	Part	Extension of Time To File Form 5330 (see instructions)					
b Enter the payment amount attached	4			of Form 5330.			
c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date	a	Enter the Code section(s) imposing the tax	► a	<u> </u>		· 	
	b	Enter the payment amount attached		▶	b		
	с 5		/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.

#### 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

2018

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information				
For calend	dar plan year 2018 or fi	scal plan year beginning	07/01/2018	and ending 06/30	/2019	
A This re	eturn/report is for:	a multiemployer plan;		loyer plan (Filers checking this nployer information in accorda		ons.)
<b>B</b> This re	B This return/report is:    a single-employer plan;   a DFE (specify)   the first return/report;   the final return/report;   a short plan year return/report (less than 12 months).					
C If the p	olan is a collectively-barg	ained plan, check here			▶□	
<b>D</b> Check	box if filing under:	× Form 5558;	automatic exte	nsion;	the DFVC pro	gram;
		special extension (enter descriptio	,			
Part II	Basic Plan Info	rmation enter all requested in	formation			
	ne of plan se Medical Imagir	ng & Breast Center at the V	Villages, Welfa	are Plan	<b>1b</b> Three-digit plan number (PN) ▶	501
					1c Effective date of pla 12/01/2006	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 ZIP or foreign postal code (If foreign, see instructions)  2b Employer Identification Number (EIN) 59-3522082					ion	
Lake Medical Imaging & Breast Center at the			Villages, LLC		2c Plan Sponsor's teler number (352) 365-285	
341 Oak T	errace Drive	Lake Medic	al Imaging	2d Business code (see		
Suite 112	2	734 N 3RD	St	instructions)		
US Leesbu	rg FL 34748	US Leesbur	g FL 34748-5287		621399	
Caution: /	A penalty for the late or	r incomplete filing of this return/repo	rt will be assessed ι	unless reasonable cause is e	established.	
Under pen statements	alties of perjury and others and attachments, as we	er penalties set forth in the instructions, ell as the electronic version of this retur	I declare that I have en/report, and to the be	examined this return/report, inc est of my knowledge and belief	cluding accompanying school, it is true, correct, and co	edules, mplete.
SIGN HERE	Chali Ball	) 5	01/07/2020	Chuck Bentley		
	Signature of plan ad	ministrator	Date	Enter name of individual sign	ning as plan administrator	
SIGN HERE	Chale Ball	? \$	01/07/2020	Chuck Bentley		
	Signature of employ	er/plan sponsor	Date	Enter name of individual sig	ning as employer or plan s	ponsor

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

SIGN HERE

Signature of DFE

Form 5500 (2018)

Enter name of individual signing as DFE

v. 171027

	Form 5500 (2018)			Page <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor				<b>3b</b> Admini	strator's EIN
					3c Admini numbe	strator's telephone
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 EIN	
	Sponsor's name Plan name				4d PN	
5	Total number of participants at the beginning of the plan year				5	193
6	Number of participants as of the end of the plan year unless otherwise stated	d (welfa	are plan	ns complete only lines 6a(1),	3	193
	<b>6a(2), 6b, 6c,</b> and <b>6d</b> ).					
a(	1) Total number of active participants at the beginning of the plan year				. 6a(1)	193
a(	2) Total number of active participants at the end of the plan year				. 6a(2)	203
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	203
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive b	enefits		. 6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>			· • • • • • • • • •	. 6f	
g	Number of participants with account balances as of the end of the plan year	(only d	efined (	contribution plans		
	complete this item)	• •		• • • • • • • • •	. 6g	
h	Number of participants who terminated employment during the plan year with less than 100% vested				. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multien	nployer	plans complete this item)	7	
8a	If the plan provides pension benefits, enter the applicable pension feature c	odes fr	om the	List of Plan Characteristics Co	des in the instru	ıctions:
b	If the plan provides welfare benefits, enter the applicable welfare feature co	des fro	m the L	ist of Plan Characteristics Cod	es in the instruc	tions:
	4B 4D 4E 4F 4H					
9a	Plan funding arrangement (check all that apply)	9b	Plan t	penefit arrangement (check all	that apply)	
	(1) X Insurance		(1)	x Insurance		
	(2) Code section 412(e)(3) insurance contracts (3) Trust		(2)	Code section 412(e)(3) Trust	insurance contr	acts
	(4) X General assets of the sponsor		(3) (4)	X General assets of the sp	oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attach	ned, and	l, where	indicated, enter the number atta	ched. (See instru	ctions)
а	Pension Schedules	b	Gene	ral Schedules		
	(1) R (Retirement Plan Information)		(1)	H (Financial Inf	ormation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		ormation - Smal	l Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary		(3)	X 4 A (Insurance In	,	-\
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(4) (5)	<u> </u>	vider Informatio pating Plan Info	•
	Information) - signed by the plan actuary		(6)		ansaction Sche	

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.) • • • • • • • • • • • • • • • • • • •							
If "Yes" is cl	If "Yes" is checked, complete lines 11b and 11c.						
11b Is the plan of	11b Is the plan currently in compliance with the Form M-1 filling requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt 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 Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)							
Receipt Cor	nfirmation Code						

Form 5500 (2018)

Page 3

#### E-SIGNATURE AUTHORIZATION

for

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

For Plan Year 07/01/2018 through 06/30/2019

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 (EFASI).

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.

Challe Bally	Chale Bally
Plan Administrator	Plan Sponsor
January 7, 2020	January 7, 2020
Date	Date