

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 2020 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>	
A	This return/report is for: ☒ a single-employer plan ☐ a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
B	This return/report is ☐ the first return/report ☒ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ DFVC program ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information		
1a	Name of plan <u>EMERGENCY PHYSICIANS OF NORTHWEST OHIO, INC. DEFINED BENEFIT PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>002</u>
		1c	Effective date of plan <u>01/01/2011</u>
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 ZIP or postal code (if foreign, see instructions) <u>EMERGENCY PHYSICIANS OF NORTHWEST OHIO, INC.</u> <u>P.O. BOX 351357</u> <u>TOLEDO, OH 43635</u>	2b	Employer Identification Number (EIN) <u>81-0547599</u>
		2c	Sponsor's telephone number <u>567-408-2002</u>
		2d	Business code (see instructions) <u>621498</u>
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	4b	EIN
		4d	PN
5a	Total number of participants at the beginning of the plan year	5a	<u>49</u>
b	Total number of participants at the end of the plan year	5b	<u>0</u>
c	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	5c	
d(1)	Total number of active participants at the beginning of the plan year	5d(1)	<u>49</u>
d(2)	Total number of active participants at the end of the plan year	5d(2)	<u>0</u>
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	<u>0</u>
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.	10/13/2021	EDWARD SCHOFIELD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2020)
v.200204

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ 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.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☒ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4322504. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	10537029	0
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	10537029	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	1348902	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	153560	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		1502462
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	11996244	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	43247	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		12039491
i Net income (loss) (subtract line 8h from line 8c)	8i		-10537029
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
1A 1D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a 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		☒	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		☒	
c Was the plan covered by a fidelity bond?	10c	☒		500000
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		☒	
e 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		☒	
f Has the plan failed to provide any benefit when due under the plan?	10f		☒	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		☒	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h			
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 12 below..... ☒ Yes ☐ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40..... **11a** 0

b **PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If 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**

c Enter the amount contributed by the employer to the plan for this plan year **12c**

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

e Will the minimum funding amount reported on line 12d be met by the funding deadline?..... ☐ Yes ☐ No ☐ N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☒ Yes ☐ 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? ☒ Yes ☐ No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

<div>SCHEDULE SB</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>		<div>Single-Employer Defined Benefit Plan</div> <div>Actuarial Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).</div> <div>▶ File as an attachment to Form 5500 or 5500-SF.</div>		<div>OMB No. 1210-0110</div> <div>2020</div> <div>This Form is Open to Public Inspection</div>	
For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020					
▶ Round off amounts to nearest dollar.					
▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.					
A Name of plan EMERGENCY PHYSICIANS OF NORTHWEST OHIO, INC. DEFINED BENEFIT PLAN			B Three-digit plan number (PN) ▶		002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF EMERGENCY PHYSICIANS OF NORTHWEST OHIO, INC.			D Employer Identification Number (EIN) 81-0547599		
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B			F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500		
Part I Basic Information					
1 Enter the valuation date: Month 01 Day 01 Year 2020					
2 Assets:					
a Market value			2a	10520344	
b Actuarial value			2b	10520344	
3 Funding target/participant count breakdown			(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment.....			0	0	0
b For terminated vested participants.....			0	0	0
c For active participants			46	8271446	8271446
d Total			46	8271446	8271446
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... ☐					
a Funding target disregarding prescribed at-risk assumptions			4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor			4b		
5 Effective interest rate			5	5.30 %	
6 Target normal cost.....			6	0	
Statement by Enrolled Actuary					
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.					
SIGN HERE					
Signature of actuary			09/27/2021		
HANS NIENABER			Date		
Type or print name of actuary			20-05737		
CUNI, RUST & STRENK, INC.			Most recent enrollment number		
Firm name			513-985-6164		
4555 LAKE FOREST DRIVE, SUITE 620 CINCINNATI, OH 45242			Telephone number (including area code)		
Address of the firm					
If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐					
For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.					
Schedule SB (Form 5500) 2020 v. 200204					

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>19.30</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		1030757
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.49</u> %		56589
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		1087346
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	127.18 %
15 Adjusted funding target attainment percentage	15	127.18 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	103.52 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
11/27/2020	1348902				
Totals ▶			18(b)	1348902	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	1287351

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost**21** Discount rate:**a** Segment rates:1st segment:
3.64 %2nd segment:
5.21 %3rd segment:
5.94 %☐ N/A, full yield curve used**b** Applicable month (enter code)**21b**

0

22 Weighted average retirement age**22**

65

23 Mortality table(s) (see instructions)

Prescribed - combined



Prescribed - separate



Substitute

Part VI Miscellaneous Items**24** Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**25** Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**26** Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ☒ Yes ☐ No**27** If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.**27****Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years****28** Unpaid minimum required contributions for all prior years **28** 0**29** Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0**30** Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0**Part VIII Minimum Required Contribution For Current Year****31** Target normal cost and excess assets (see instructions):**a** Target normal cost (line 6) **31a** 0**b** Excess assets, if applicable, but not greater than line 31a **31b** 0**32** Amortization installments:**a** Net shortfall amortization installment Outstanding Balance 0 Installment 0**b** Waiver amortization installment 0 0**33** If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33****34** Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) **34** 0**35** Balances elected for use to offset funding requirement Carryover balance Prefunding balance Total balance 0**36** Additional cash requirement (line 34 minus line 35) **36** 0**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 1287351**38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36) **38a** 1287351**b** Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b** 0**39** Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0**40** Unpaid minimum required contributions for all years **40** 0**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)****41** If an election was made to use PRA 2010 funding relief for this plan:**a** Schedule elected ☐ 2 plus 7 years ☐ 15 years**b** Eligible plan year(s) for which the election in line 41a was made ☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2020 This Form is Open to Public Inspection
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For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

► Round off amounts to nearest dollar.

► Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Emergency Physicians of Northwest Ohio, Inc.	D Employer Identification Number (EIN) 81-0547599	
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B		
F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500		

Part I Basic Information				
1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2020</u>				
2 Assets:				
a Market value	2a	10,520,344		
b Actuarial value	2b	10,520,344		
3 Funding target/participant count breakdown:	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target	
a For retired participants and beneficiaries receiving payment	0	0	0	
b For terminated vested participants	0	0	0	
c For active participants	46	8,271,446	8,271,446	
d Total	46	8,271,446	8,271,446	
4 If the plan is in at-risk status, check the box and complete lines (a) and (b) ☐				
a Funding target disregarding prescribed at-risk assumptions	4a			
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b			
5 Effective interest rate	5	5.30 %		
6 Target normal cost	6	0		

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	 Signature of actuary Hans Nienaber Type or print name of actuary Cuni, Rust & Strenk, Inc. Firm name 4555 Lake Forest Drive Suite 620 US Cincinnati OH 45242 Address of the firm	09/27/2021 Date 20-05737 Most recent enrollment number (513) 985-6164 Telephone number (including area code)
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>19.30</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		1,030,757
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.49</u> %.....		56,589
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance .		1,087,346
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	127.18 %
15 Adjusted funding target attainment percentage	15	127.18 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	103.52 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
11/27/2020	1,348,902				
Totals ▶			18(b)	1,348,902	18(c) 0

19 Discounted employer contributions -- see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date ..	19c	1,287,351

20 Quarterly contributions and liquidity shortfalls:**a** Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No**b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No**c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used To Determine Funding Target and Target Normal Cost**21** Discount rate:**a** Segment rates:1st segment:
3.64 %2nd segment:
5.21 %3rd segment:
5.94 %☐ N/A, full yield curve used**b** Applicable month (enter code)**21b****0****22** Weighted average retirement age**22****65****23** Mortality table(s) (see instructions)☒ Prescribed - combined☐ Prescribed - separate☐ Substitute**Part VI Miscellaneous items****24** Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment ☐ Yes ☒ No**25** Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment ☐ Yes ☒ No**26** Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment ☒ Yes ☐ No**27** If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment**27****Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years****28** Unpaid minimum required contributions for all prior years**28****0****29** Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)**29****0****30** Remaining amount of unpaid minimum required contributions (line 28 minus line 29)**30****0****Part VIII Minimum Required Contribution For Current Year****31** Target normal cost and excess assets (see instructions):**a** Target normal cost (line 6)**31a****0****b** Excess assets, if applicable, but not greater than line 31a**31b****0****32** Amortization installments:**a** Net shortfall amortization installment**0****0****b** Waiver amortization installment**0****0****33** If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount**33****34** Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)**34****0**

Carryover balance

Prefunding Balance

Total balance

35 Balances elected for use to offset funding requirement**0****0****0****36** Additional cash requirement (line 34 minus line 35)**36****0****37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)**37****1,287,351****38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36)**38a****1,287,351****b** Portion included in line 38a attributable to use of prefunding and funding standard carryover balances**38b****0****39** Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)**39****0****40** Unpaid minimum required contributions for all years**40****0****Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)****41** If an election was made to use PRA 2010 funding relief for this plan:**a** Schedule elected ☐ 2 plus 7 years ☐ 15 years**b** Eligible plan year(s) for which the election in line 41a was made ☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011

2020 Schedule SB, line 19(c) – Discounted Employer Contributions

Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan
EIN: 81-0547599
PN: 002

Effective Interest Rate: 5.30%
Effective Interest Rate for Late Quarterlies: N/A

<u>Date</u>	<u>Contribution Amount</u>	<u># Days to 1/1/2020</u>	<u>Discounted Contributions @ 5.30%</u>
11/27/2020	1,348,902	331	1,287,351
Totals	1,348,902		1,287,351

2020 Schedule SB, line 22 -- Description of Weighted Average Retirement Age
Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan
EIN: 81-0547599
PN: 002

(A)	(B)	(C)	(D)	(E)
Retirement Age	Retirement Rates	Fraction Remaining	Probability Distribution	Sum Weighted Average Age
65	100.00%	0.00000	100.00%	65.00000

Weighted Average Retirement Age

65.0

The Retirement Rates (Column B) at each Early Retirement Age (Column A) are converted to a probability distribution (Column D). The products of Column A and Column D are summed to determine the resulting Weighted Average Retirement Age.

2020 Schedule SB, Part V – Statement of Actuarial Assumptions/Methods
Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan
EIN: 81-0547599
PN: 002

1. Interest Rates:

Minimum Funding

Segment 1	3.64%
Segment 2	5.21%
Segment 3	5.94%

Post-retirement Lump Sum Rate	5.50%
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2. Mortality Rates:

Preretirement: None.

Postretirement: Funding: IRS 2020 Combined Small Plan Mortality Table.

ASC 960/Lump Sums: 1994 Group Annuity Reserve Table 50% male/50% female

3. Salary Scale: None.

4. Retirement Rates: Normal Retirement Age under the Plan.

5. Termination Rates: None.

6. Disability Rates: None.

7. Plan Expenses: None.

2020 Schedule SB, Part V – Statement of Actuarial Assumptions/Methods
Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan
EIN: 81-0547599
PN: 002

- | | |
|---|---|
| 8. <u>Actuarial Cost Method:</u> | Unit Credit under PPA Rules. |
| | |
| 9. <u>Asset Valuation Method:</u> | Market Value. |
| | |
| 10. <u>Assumed Form of Benefit Payment:</u> | Lump sum distribution. |
| | |
| 11. <u>Rationale for Assumptions:</u> | The IRS segment rates and mortality tables are those required by IRS regulations. The selection of other actuarial assumptions is based on the actuary's best estimate of future expectations based on an examination of historical results compared to expectations, periodic experience studies, Society of Actuaries mortality studies, and any reasonably certain information about future expected plan changes. |
| | |
| 12. <u>Changes Since Last Year:</u> | Interest rates updated to comply with the Pension Protection Act of 2006 (PPA). |

2020 Schedule SB, Part V – Statement of Plan Provisions

Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan

EIN: 81-0547599

PN: 002

1. Effective Date: January 1, 2011

2. Plan Year: January 1st through December 31st.

3. Covered Employees: Employees of Emergency Physicians of Northwest Ohio, Inc.

4. Eligibility:

Full-Time Employee: Later of the Employee's Date of Employment or the attainment of age 21.
Part-Time Employee: Later of completion of one year of service or the attainment of age 21.

No new participants will enter the Plan after May 25, 2017.

5. Average Monthly Compensation: Average monthly compensation for the highest thirty-six consecutive months.

6. Vesting Service: Vesting Service is calculated using the elapsed time method.

7. Benefit Service: One Year of Benefit Service is granted for each Plan Year in which the Employee was credited with 1,000 hours while a Plan Participant.

2020 Schedule SB, Part V – Statement of Plan Provisions

Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan

EIN: 81-0547599

PN: 002

8. Normal Retirement:

a. Eligibility Later of attainment of Age 65 or the fifth anniversary of Plan participation.

b. Monthly Benefit Various percentages (see below) of Average Monthly Compensation per Year of Benefit Service. All benefits are offset by the benefit equivalent to the profit sharing contribution for each Year of Benefit Service. Maximum offset per Year of Benefit Service is 0.50% of Average Monthly Compensation.

Prior to January 1, 2015:

<u>Group</u>	<u>Percentage</u>
One	8.46%
Two	7.50%
Three	4.50%
Four	3.50%
Five	2.50%
Six	0.50%

After December 31, 2014:

<u>Group</u>	<u>Percentage</u>
One	8.46%
Two	7.50%
Three	3.75%
Four	3.50%
Five	3.25%
Six	3.00%
Seven	0.50%

No additional benefits will accrue after May 25, 2017.

9. Early Retirement:

a. Eligibility No Early Retirement benefit offered.

b. Monthly Benefit N/A

2020 Schedule SB, Part V – Statement of Plan Provisions

Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan

EIN: 81-0547599

PN: 002

10. Vested Retirement:

- | | |
|--------------------|---|
| a. Eligibility | 3 Years of Vesting Service. |
| b. Monthly Benefit | Accrued Benefit times the participant's vesting percentage. |

11. Disability Retirement:

- | | |
|----------------|--|
| a. Eligibility | Total and permanent disability. |
| b. Benefit | Accrued Benefit as of the Disability Retirement Date, reduced by one-fifteenth (1/15) for each of the first five years and one-thirtieth (1/30) for each of the next five years by which the starting date of the benefit precedes the Normal Retirement Date, and reduced actuarially for each additional year. |

12. Pre-Retirement Death:

- | | |
|----------------|---|
| a. Eligibility | A Participant with an Accrued Benefit. |
| b. Benefit | Actuarial Present Value of the Participant's Accrued Benefit. |

13. Payment Forms:

- | | |
|-------------|---|
| a. Normal | Life annuity for single participants and an Actuarially Equivalent 50% Joint & Survivor annuity for married participants. |
| b. Optional | Actuarially equivalent single premium, nontransferable annuity, periodic installment payments, or lump sum distribution. |

2020 Schedule SB, Part V – Statement of Plan Provisions

Plan Name: Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan

EIN: 81-0547599

PN: 002

14. Actuarial Equivalency:

a. Other than Lump Sums

Pre-retirement: No mortality and 5.50% interest.
Post-retirement: 1994 Group Annuity Reserve Table, blended 50% male/50% female, and 5.50% interest.

b. Lump Sums

Greater of the lump sum calculated using (a) and the lump sum calculated using the 417(e) Applicable Mortality Table and 417(e) Applicable Interest Rate for the fifth month prior to the beginning of the Plan Year in which the distribution occurs.

15. Maximum Annual Benefit:

\$230,000 per year for participants retiring at age 62 or later during the 2020 Plan Year.

16. Changes Since Last Year:

The Plan was terminated effective November 30, 2020.

PN: 002

[illegible]

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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2020</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>	
A This return/report is for: ☒ a single-employer plan ☐ a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)	
B This return/report is ☐ the first return/report ☒ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)	
C Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ DFVC program ☐ special extension (enter description)	

Part II	Basic Plan Information —enter all requested information		
1a Name of plan Emergency Physicians of Northwest Ohio, Inc. Defined Benefit Plan		1b Three-digit plan number (PN) ▶	002
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 ZIP or foreign postal code (if foreign, see instructions) Emergency Physicians of Northwest Ohio, Inc. P.O. Box 351357 Toledo OH 43635		1c Effective date of plan 01/01/2011	
		2b Employer Identification Number (EIN) 81-0547599	
		2c Sponsor's telephone number (567) 408-2002	
		2d Business code (see instructions) 621498	
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		4b EIN 4d PN	
5a Total number of participants at the beginning of the plan year		5a	49
b Total number of participants at the end of the plan year		5b	0
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		5c	
d(1) Total number of active participants at the beginning of the plan year		5d(1)	49
d(2) Total number of active participants at the end of the plan year		5d(2)	0
e 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/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		10-13-21	Edward Schofield
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor