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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br>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).<br><br><p style="text-align: center;">▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p> | OMB Nos. 1210-0110<br>1210-0089<br><br><div style="text-align: center; font-size: 1.2em; font-weight: bold;">2020</div><br><br><b>This Form is Open to Public Inspection</b> |
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|                                                                                                          |                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b>                                                                                            | <b>Annual Report Identification Information</b>                                                                                                                                                                                                                                                                                           |
| For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u> |                                                                                                                                                                                                                                                                                                                                           |
| <b>A</b> This return/report is for:                                                                      | <input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)<br><input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) ____ |
| <b>B</b> This return/report is:                                                                          | <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report<br><input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)                                                                                                     |
| <b>C</b> If the plan is a collectively-bargained plan, check here. . . . .                               | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |
| <b>D</b> Check box if filing under:                                                                      | <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program<br><input type="checkbox"/> special extension (enter description)                                                                                                                                    |

|                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                                                                                                                                                                              | <b>Basic Plan Information</b> —enter all requested information                                                                                                                                                                                                                                                                              |                                                                     |                                                                  |                                                             |  |
| <b>1a</b> Name of plan<br><u>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN</u>                                                                                                                                                                                                                                                                                             | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>101</u></td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan<br/><u>01/01/2012</u></td> </tr> </table>                             | <b>1b</b> Three-digit plan number (PN) ▶                            | <u>101</u>                                                       | <b>1c</b> Effective date of plan<br><u>01/01/2012</u>       |  |
| <b>1b</b> Three-digit plan number (PN) ▶                                                                                                                                                                                                                                                                                                                                                    | <u>101</u>                                                                                                                                                                                                                                                                                                                                  |                                                                     |                                                                  |                                                             |  |
| <b>1c</b> Effective date of plan<br><u>01/01/2012</u>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br><u>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER</u><br><br><u>1001 MCARTHUR DRIVE</u><br><u>MANCHESTER, TN 37355</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>2b</b> Employer Identification Number (EIN)<br/><u>46-0485169</u></td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number<br/><u>931-728-3586</u></td> </tr> <tr> <td><b>2d</b> Business code (see instructions)<br/><u>622000</u></td> </tr> </table> | <b>2b</b> Employer Identification Number (EIN)<br><u>46-0485169</u> | <b>2c</b> Plan Sponsor's telephone number<br><u>931-728-3586</u> | <b>2d</b> Business code (see instructions)<br><u>622000</u> |  |
| <b>2b</b> Employer Identification Number (EIN)<br><u>46-0485169</u>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2c</b> Plan Sponsor's telephone number<br><u>931-728-3586</u>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2d</b> Business code (see instructions)<br><u>622000</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 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.

|                  |                                                   |            |                                                              |
|------------------|---------------------------------------------------|------------|--------------------------------------------------------------|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/15/2021 | PHIL TISUE                                                   |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |                                                   |            |                                                              |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |                                                   |            |                                                              |
|                  | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

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

Form 5500 (2020)  
v. 200204

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor<br><br>TAG RESOURCES, LLC<br><br>6501 DEANE HILL DRIVE<br>KNOXVILLE, TN 37919                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>3b</b> Administrator's EIN<br>62-1874769<br><br><b>3c</b> Administrator's telephone number<br>865-670-1844                                       |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                   |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>5</b> 226                                                                                                                                        |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><br><b>a(1)</b> Total number of active participants at the beginning of the plan year.....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>6a(1)</b> 207<br><b>6a(2)</b> 195<br><b>6b</b> 0<br><b>6c</b> 20<br><b>6d</b> 215<br><b>6e</b> 0<br><b>6f</b> 215<br><b>6g</b> 59<br><b>6h</b> 1 |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>7</b>                                                                                                                                            |
| <b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:<br>2T 2J 2K 2F 2G 3D 3B<br><br><b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
| <b>9a</b> Plan funding arrangement (check all that apply)<br><b>(1)</b> <input checked="" type="checkbox"/> Insurance<br><b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br><b>(3)</b> <input checked="" type="checkbox"/> Trust<br><b>(4)</b> <input type="checkbox"/> General assets of the sponsor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>9b</b> Plan benefit arrangement (check all that apply)<br><b>(1)</b> <input checked="" type="checkbox"/> Insurance<br><b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br><b>(3)</b> <input checked="" type="checkbox"/> Trust<br><b>(4)</b> <input type="checkbox"/> General assets of the sponsor                                                                                                                                                                                                                                       |                                                                                                                                                     |
| <b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
| <b>a Pension Schedules</b><br><b>(1)</b> <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)<br><br><b>(2)</b> <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br><br><b>(3)</b> <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>b General Schedules</b><br><b>(1)</b> <input checked="" type="checkbox"/> <b>H</b> (Financial Information)<br><b>(2)</b> <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)<br><b>(3)</b> <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information)<br><b>(4)</b> <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)<br><b>(5)</b> <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)<br><b>(6)</b> <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules) |                                                                                                                                                     |

**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.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

**11c** Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 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 \_\_\_\_\_

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2020</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                                              |                                                      |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020                   |                                                      |
| A Name of plan<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN                             | B Three-digit plan number (PN) ▶ 101                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER | D Employer Identification Number (EIN)<br>46-0485169 |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I | Information Concerning Insurance Contract Coverage, Fees, and Commissions | Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|

1 Coverage Information:

(a) Name of insurance carrier  
TRANSAMERICA LIFE INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 39-0989781 | 86231         | 931061-00052                          | 215                                                                         | 01/01/2020              | 12/31/2020 |

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 5456                                 | 0                             |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
FSC AGENCY INC  
DAVID STITES  
2300 WINDY RIDGE PKWY SE, STE  
ATLANTA, GA 30339

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 5456                                          | 0                               | N/A         | 3                     |

(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 | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
|                                               |                                 |             |                       |

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

**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.

|          |                                                                                                                                                                                                                                                                |              |         |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------|
| <b>4</b> | Current value of plan's interest under this contract in the general account at year end .....                                                                                                                                                                  | <b>4</b>     |         |
| <b>5</b> | Current value of plan's interest under this contract in separate accounts at year end.....                                                                                                                                                                     | <b>5</b>     | 1487462 |
| <b>6</b> | Contracts With Allocated Funds:                                                                                                                                                                                                                                |              |         |
| <b>a</b> | State the basis of premium rates ▶                                                                                                                                                                                                                             |              |         |
| <b>b</b> | Premiums paid to carrier .....                                                                                                                                                                                                                                 | <b>6b</b>    |         |
| <b>c</b> | Premiums due but unpaid at the end of the year .....                                                                                                                                                                                                           | <b>6c</b>    |         |
| <b>d</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶                                                          | <b>6d</b>    |         |
| <b>e</b> | Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶                                                                                       |              |         |
| <b>f</b> | If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>                                                                                                                              |              |         |
| <b>7</b> | Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)                                                                                                                                                  |              |         |
| <b>a</b> | Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment (4) <input checked="" type="checkbox"/> other ▶ STABLE VALUE OPTION |              |         |
| <b>b</b> | Balance at the end of the previous year .....                                                                                                                                                                                                                  | <b>7b</b>    | 145311  |
| <b>c</b> | Additions: (1) Contributions deposited during the year .....                                                                                                                                                                                                   | <b>7c(1)</b> | 18724   |
|          | (2) Dividends and credits.....                                                                                                                                                                                                                                 | <b>7c(2)</b> | 0       |
|          | (3) Interest credited during the year.....                                                                                                                                                                                                                     | <b>7c(3)</b> | 2547    |
|          | (4) Transferred from separate account.....                                                                                                                                                                                                                     | <b>7c(4)</b> | 105011  |
|          | (5) Other (specify below).....<br>▶ LOAN PAYMENTS                                                                                                                                                                                                              | <b>7c(5)</b> | 830     |
|          | (6) Total additions .....                                                                                                                                                                                                                                      | <b>7c(6)</b> | 127112  |
| <b>d</b> | Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                                                                                                                                                                                   | <b>7d</b>    | 272423  |
| <b>e</b> | Deductions:                                                                                                                                                                                                                                                    |              |         |
|          | (1) Disbursed from fund to pay benefits or purchase annuities during year .....                                                                                                                                                                                | <b>7e(1)</b> | 10397   |
|          | (2) Administration charge made by carrier.....                                                                                                                                                                                                                 | <b>7e(2)</b> | 472     |
|          | (3) Transferred to separate account.....                                                                                                                                                                                                                       | <b>7e(3)</b> | 94080   |
|          | (4) Other (specify below).....<br>▶ ADMIN AND TPA FEES                                                                                                                                                                                                         | <b>7e(4)</b> | 130     |
|          | (5) Total deductions .....                                                                                                                                                                                                                                     | <b>7e(5)</b> | 105079  |
| <b>f</b> | Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....                                                                                                                                                                  | <b>7f</b>    | 167344  |

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)     
**b** ☐ Dental     
**c** ☐ Vision     
**d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)     
**f** ☐ Long-term disability     
**g** ☐ Supplemental unemployment     
**h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)     
**j** ☐ HMO contract     
**k** ☐ PPO contract     
**l** ☐ Indemnity contract  
**m** ☐ Other (specify) ▶

**9** Experience-rated contracts:

|                                                                                                                                                    |                 |                 |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|---|
| <b>a</b> Premiums: (1) Amount received .....                                                                                                       | <b>9a(1)</b>    |                 |   |
| (2) Increase (decrease) in amount due but unpaid .....                                                                                             | <b>9a(2)</b>    |                 |   |
| (3) Increase (decrease) in unearned premium reserve .....                                                                                          | <b>9a(3)</b>    |                 |   |
| (4) Earned ((1) + (2) - (3)) .....                                                                                                                 |                 | <b>9a(4)</b>    | 0 |
| <b>b</b> Benefit charges (1) Claims paid .....                                                                                                     | <b>9b(1)</b>    |                 |   |
| (2) Increase (decrease) in claim reserves .....                                                                                                    | <b>9b(2)</b>    |                 |   |
| (3) Incurred claims (add (1) and (2)) .....                                                                                                        |                 | <b>9b(3)</b>    | 0 |
| (4) Claims charged .....                                                                                                                           |                 | <b>9b(4)</b>    |   |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                      |                 |                 |   |
| (A) Commissions .....                                                                                                                              | <b>9c(1)(A)</b> |                 |   |
| (B) Administrative service or other fees .....                                                                                                     | <b>9c(1)(B)</b> |                 |   |
| (C) Other specific acquisition costs .....                                                                                                         | <b>9c(1)(C)</b> |                 |   |
| (D) Other expenses .....                                                                                                                           | <b>9c(1)(D)</b> |                 |   |
| (E) Taxes .....                                                                                                                                    | <b>9c(1)(E)</b> |                 |   |
| (F) Charges for risks or other contingencies .....                                                                                                 | <b>9c(1)(F)</b> |                 |   |
| (G) Other retention charges .....                                                                                                                  | <b>9c(1)(G)</b> |                 |   |
| (H) Total retention .....                                                                                                                          |                 | <b>9c(1)(H)</b> | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |   |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                |                 | <b>9d(1)</b>    |   |
| (2) Claim reserves .....                                                                                                                           |                 | <b>9d(2)</b>    |   |
| (3) Other reserves .....                                                                                                                           |                 | <b>9d(3)</b>    |   |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....                                           |                 | <b>9e</b>       |   |

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> |  |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |  |

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☒ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>2020</b>                                    |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>This Form is Open to Public Inspection.</b> |

|                                                                                                                     |                                                             |     |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----|
| For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020                          |                                                             |     |
| <b>A</b> Name of plan<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN                             | <b>B</b> Three-digit plan number (PN) ▶                     | 101 |
|                                                                                                                     |                                                             |     |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER | <b>D</b> Employer Identification Number (EIN)<br>46-0485169 |     |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☒ Yes ☐ No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
| TRANSAMERICA LIFE INSURANCE COMPANY                                                                               |
| 39-0989781                                                                                                        |

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|-------------------------------------------------------------------------------------------------------------------|

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|-------------------------------------------------------------------------------------------------------------------|

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|-------------------------------------------------------------------------------------------------------------------|

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

TRANSAMERICA LIFE INSURANCE COMPANY

39-0989781

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 15 37 52<br>62 64 67   | RECORD KEEPER                                                                                     | 4293                                                                   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

(a) Enter name and EIN or address (see instructions)

TAG RESOURCES, LLC

62-1874769

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 15 37 64               | RECORD KEEPER                                                                                     | 1921                                                                   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

(a) Enter name and EIN or address (see instructions)

FSC SECURITIES CORP

58-1152673

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 22 23 53               | BROKER                                                                                            | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 171                                                                                                                                                                             | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                               |                                                                                                          |                                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                    | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                              |                                                                                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                            |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                               |                                                                                                          |                                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                    | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                              |                                                                                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                            |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                               |                                                                                                          |                                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                    | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                              |                                                                                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                            |

**Part I Service Provider Information (continued)**

**3.** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |

**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|--------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------|
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |

**Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)**  
(complete as many entries as needed)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                                                                                                                                                                                                               |                                                                                                                                                                                                                              |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>SCHEDULE D</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small> | <b>DFE/Participating Plan Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2020</b><br><br><b>This Form is Open to Public Inspection.</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

|                                                                                                                                   |                                                                            |            |
|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------|
| <b>A</b> Name of plan<br><u>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN</u>                                    | <b>B</b> Three-digit plan number (PN) <span style="float: right;">►</span> | <u>101</u> |
|                                                                                                                                   |                                                                            |            |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><u>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER</u> | <b>D</b> Employer Identification Number (EIN)<br><u>46-0485169</u>         |            |

|               |                                                                                                                                                                                  |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b> | <b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b><br>(Complete as many entries as needed to report all interests in DFEs) |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                              |                               |                                                                                                                                                      |  |  |
|----------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>AMERICAN CENTURY FOCUSED GLOBAL GRO</u>    |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-571</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>20082</u></span>  |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>DFA EMERGING MARKETS CORE EQUITY RE</u>    |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-762</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>22987</u></span>  |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>DFA U.S. SMALL CAP PORTFOLIO RET OP</u>    |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-725</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>9315</u></span>   |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>EATON VANCE ATLANTA CAP SMID-CAP RE</u>    |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-638</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>56120</u></span>  |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>EATON VANCE HIGH INCOME OPPORTUNITI</u>    |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-727</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>316</u></span>    |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>GOLDMAN SACHS BOND RET OPT</u>             |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-642</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>46917</u></span>  |  |  |
|                                                                                              |                               |                                                                                                                                                      |  |  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>JPMORGAN U.S. EQUITY RET OPT</u>           |                               |                                                                                                                                                      |  |  |
| <b>b</b> Name of sponsor of entity listed in (a): <u>TRANSAMERICA LIFE INSURANCE COMPANY</u> |                               |                                                                                                                                                      |  |  |
| <b>c</b> EIN-PN <u>39-0989781-297</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;"><u>103733</u></span> |  |  |

|                                                                                       |                        |                                                                                                            |
|---------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: MORGAN STANLEY GROWTH RET OPT          |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-166                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 73977  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: PRINCIPAL DIVERSIFIED REAL ASSET RE    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-780                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 6878   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET INTERNATIONAL INDEX RE    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-035                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 44388  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET RUSSELL SMALL CAP INDE    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-033                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 72191  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET S&P MID CAP INDEX RET     |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-036                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 25244  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2020    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-077                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 19579  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2025    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-078                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 256304 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2030    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-079                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 29691  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2035    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-080                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 180006 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2040    |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY |                        |                                                                                                            |
| <b>c</b> EIN-PN 39-0989781-081                                                        | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 355002 |

**a** Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2045

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-082 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 21800 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT 2050

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                          |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-083 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3352 |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET TARGET RETIREMENT INCO

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-075 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11345 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: STATE STREET U.S. BOND INDEX RET OP

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-037 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 32548 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: T. ROWE PRICE EQUITY INCOME RET OPT

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-605 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 16022 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: TA VANGUARD TOTAL STOCK MARKET INDE

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-114 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 34771 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: TRANSAMERICA INTERNATIONAL EQUITY R

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-608 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 21559 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: TRANSAMERICA PARTNERS STOCK INDEX R

**b** Name of sponsor of entity listed in (a): TRANSAMERICA LIFE INSURANCE COMPANY

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 39-0989781-587 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 23335 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**Part II Information on Participating Plans (to be completed by DFEs)**

(Complete as many entries as needed to report all participating plans)

**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
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plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
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plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                              |                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).<br><br><b>► File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2020</b><br><br><b>This Form is Open to Public Inspection</b> |
| For calendar plan year 2020 or fiscal plan year beginning <b>01/01/2020</b> and ending <b>12/31/2020</b>                                                                                                                                                                 |                                                                                                                                                                                                                                                                              |                                                                                                          |
| <b>A</b> Name of plan<br><b>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN</b>                                                                                                                                                                           | <b>B</b> Three-digit plan number (PN) <b>►</b>                                                                                                                                                                                                                               | <b>101</b>                                                                                               |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER</b>                                                                                                                                               | <b>D</b> Employer Identification Number (EIN)<br><b>46-0485169</b>                                                                                                                                                                                                           |                                                                                                          |

| Part I Asset and Liability Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |                       |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| 1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. <b>Round off amounts to the nearest dollar.</b> MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions. |                 |                       |                 |
| Assets                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 | (a) Beginning of Year | (b) End of Year |
| <b>a</b> Total noninterest-bearing cash.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>1b(1)</b>    |                       |                 |
| <b>(2)</b> Participant contributions.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>1b(2)</b>    | 13526                 | 5206            |
| <b>(3)</b> Other .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>1c(8)</b>    | 40850                 | 26560           |
| <b>(9)</b> Value of interest in common/collective trusts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>1c(10)</b>   | 1254570               | 1487462         |
| <b>(11)</b> Value of interest in master trust investment accounts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>1c(13)</b>   |                       |                 |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>1c(14)</b>   | 145311                | 167344          |
| <b>(15)</b> Other.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>1c(15)</b>   |                       |                 |

|                    |                                                                  | (a) Beginning of Year | (b) End of Year |
|--------------------|------------------------------------------------------------------|-----------------------|-----------------|
| <b>1d</b>          | Employer-related investments:                                    |                       |                 |
| (1)                | Employer securities.....                                         | <b>1d(1)</b>          |                 |
| (2)                | Employer real property.....                                      | <b>1d(2)</b>          |                 |
| <b>e</b>           | Buildings and other property used in plan operation .....        | <b>1e</b>             |                 |
| <b>f</b>           | Total assets (add all amounts in lines 1a through 1e) .....      | <b>1f</b>             | 1454257 1686572 |
| <b>Liabilities</b> |                                                                  |                       |                 |
| <b>g</b>           | Benefit claims payable .....                                     | <b>1g</b>             |                 |
| <b>h</b>           | Operating payables .....                                         | <b>1h</b>             |                 |
| <b>i</b>           | Acquisition indebtedness.....                                    | <b>1i</b>             |                 |
| <b>j</b>           | Other liabilities.....                                           | <b>1j</b>             | 0 10502         |
| <b>k</b>           | Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b>             | 0 10502         |
| <b>Net Assets</b>  |                                                                  |                       |                 |
| <b>l</b>           | Net assets (subtract line 1k from line 1f) .....                 | <b>1l</b>             | 1454257 1676070 |

**Part II Income and Expense Statement**

**2** Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

|               |                                                                                                        | (a) Amount      | (b) Total |
|---------------|--------------------------------------------------------------------------------------------------------|-----------------|-----------|
| <b>Income</b> |                                                                                                        |                 |           |
| <b>a</b>      | <b>Contributions:</b>                                                                                  |                 |           |
| (1)           | Received or receivable in cash from: <b>(A)</b> Employers .....                                        | <b>2a(1)(A)</b> |           |
|               | <b>(B)</b> Participants .....                                                                          | <b>2a(1)(B)</b> | 177117    |
|               | <b>(C)</b> Others (including rollovers).....                                                           | <b>2a(1)(C)</b> |           |
| (2)           | Noncash contributions .....                                                                            | <b>2a(2)</b>    |           |
| (3)           | Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    | 177117    |
| <b>b</b>      | <b>Earnings on investments:</b>                                                                        |                 |           |
| (1)           | Interest:                                                                                              |                 |           |
|               | <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....    | <b>2b(1)(A)</b> |           |
|               | <b>(B)</b> U.S. Government securities .....                                                            | <b>2b(1)(B)</b> |           |
|               | <b>(C)</b> Corporate debt instruments .....                                                            | <b>2b(1)(C)</b> |           |
|               | <b>(D)</b> Loans (other than to participants) .....                                                    | <b>2b(1)(D)</b> |           |
|               | <b>(E)</b> Participant loans.....                                                                      | <b>2b(1)(E)</b> | 1948      |
|               | <b>(F)</b> Other .....                                                                                 | <b>2b(1)(F)</b> | 2547      |
|               | <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                          | <b>2b(1)(G)</b> | 4495      |
| (2)           | Dividends: <b>(A)</b> Preferred stock.....                                                             | <b>2b(2)(A)</b> |           |
|               | <b>(B)</b> Common stock .....                                                                          | <b>2b(2)(B)</b> |           |
|               | <b>(C)</b> Registered investment company shares (e.g. mutual funds).....                               | <b>2b(2)(C)</b> |           |
|               | <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....              | <b>2b(2)(D)</b> | 0         |
| (3)           | Rents .....                                                                                            | <b>2b(3)</b>    |           |
| (4)           | Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                                 | <b>2b(4)(A)</b> |           |
|               | <b>(B)</b> Aggregate carrying amount (see instructions).....                                           | <b>2b(4)(B)</b> |           |
|               | <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....              | <b>2b(4)(C)</b> | 0         |
| (5)           | Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....                         | <b>2b(5)(A)</b> |           |
|               | <b>(B)</b> Other .....                                                                                 | <b>2b(5)(B)</b> |           |
|               | <b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....     | <b>2b(5)(C)</b> | 0         |

|                                                                                                 |        | (a) Amount | (b) Total |
|-------------------------------------------------------------------------------------------------|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts.....                               | 2b(6)  |            |           |
| (7) Net investment gain (loss) from pooled separate accounts.....                               | 2b(7)  |            | 248324    |
| (8) Net investment gain (loss) from master trust investment accounts .....                      | 2b(8)  |            |           |
| (9) Net investment gain (loss) from 103-12 investment entities .....                            | 2b(9)  |            |           |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) ..... | 2b(10) |            |           |
| c Other income .....                                                                            | 2c     |            |           |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total.....                | 2d     |            | 429936    |

**Expenses****e** Benefit payment and payments to provide benefits:

|                                                                                     |       |        |        |
|-------------------------------------------------------------------------------------|-------|--------|--------|
| (1) Directly to participants or beneficiaries, including direct rollovers.....      | 2e(1) | 201909 |        |
| (2) To insurance carriers for the provision of benefits .....                       | 2e(2) |        |        |
| (3) Other.....                                                                      | 2e(3) |        |        |
| (4) Total benefit payments. Add lines 2e(1) through (3) .....                       | 2e(4) |        | 201909 |
| f Corrective distributions (see instructions) .....                                 | 2f    |        |        |
| g Certain deemed distributions of participant loans (see instructions).....         | 2g    |        |        |
| h Interest expense.....                                                             | 2h    |        |        |
| i Administrative expenses: (1) Professional fees .....                              | 2i(1) |        |        |
| (2) Contract administrator fees .....                                               | 2i(2) | 6214   |        |
| (3) Investment advisory and management fees .....                                   | 2i(3) |        |        |
| (4) Other.....                                                                      | 2i(4) |        |        |
| (5) Total administrative expenses. Add lines 2i(1) through (4) .....                | 2i(5) |        | 6214   |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total..... | 2j    |        | 208123 |

**Net Income and Reconciliation**

|                                                          |       |  |        |
|----------------------------------------------------------|-------|--|--------|
| k Net income (loss). Subtract line 2j from line 2d ..... | 2k    |  | 221813 |
| l Transfers of assets:                                   |       |  |        |
| (1) To this plan.....                                    | 2l(1) |  |        |
| (2) From this plan .....                                 | 2l(2) |  |        |

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: COULTER & JUSTUS

(2) EIN: 62-1532536

**d** The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

**Part IV Compliance Questions**

**4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

**a** Was there a failure to transmit to the plan any participant contributions within the time

period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) .....

|    | Yes | No | Amount |
|----|-----|----|--------|
| 4a | X   |    | 1620   |

|                                                                                                                                                                                                                                                                                                                                                                                                 | Yes                 | No                 | Amount |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------|--------|
| <b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) .....                                                                                |                     |                    |        |
| <b>4b</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) .....                                                                                                                                                                                                            |                     |                    |        |
| <b>4c</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) .....                                                                                                                                                                                                 |                     |                    |        |
| <b>4d</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                                                                                                                                                                                        | X                   |                    | 500000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                                                                                                         |                     | X                  |        |
| <b>4f</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                                                                                                                      |                     |                    |        |
| <b>4g</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                                                                                                            |                     |                    |        |
| <b>4h</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                                                                                                                                                                                  | X                   |                    |        |
| <b>4i</b>                                                                                                                                                                                                                                                                                                                                                                                       | X                   |                    |        |
| <b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) .....                                                                                                                                                                    |                     |                    |        |
| <b>4j</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                                                                                                                                                                                             |                     |                    |        |
| <b>4k</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                                                                                                              |                     |                    |        |
| <b>4l</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                                                                                                                                                                                    |                     |                    |        |
| <b>4m</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. ....                                                                                                                                                                                                        |                     |                    |        |
| <b>4n</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     |                    |        |
| <b>5a</b> Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.                                                                                                             |                     |                    |        |
| <b>5b</b> 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.)                                                                                                                                                                                    |                     |                    |        |
| <b>5b(1)</b> Name of plan(s)                                                                                                                                                                                                                                                                                                                                                                    | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> PN(s) |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
| <b>5c</b> Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined<br>If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____. |                     |                    |        |

|                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                  |                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <div>SCHEDULE R<br/>(Form 5500)<br/><br/>Department of the Treasury<br/>Internal Revenue Service<br/><br/>Department of Labor<br/>Employee Benefits Security Administration<br/><br/>Pension Benefit Guaranty Corporation</div> | <div>Retirement Plan Information</div> <div>This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ File as an attachment to Form 5500.</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

|                                                                                                                     |                                                             |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A</b> Name of plan<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER 401(K) PLAN                             | <b>B</b> Three-digit plan number (PN) ▶ 101                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>COFFEE MEDICAL GROUP, LLC DBA UNITY MEDICAL CENTER | <b>D</b> Employer Identification Number (EIN)<br>46-0485169 |

|        |               |
|--------|---------------|
| Part I | Distributions |
|--------|---------------|

All references to distributions relate only to payments of benefits during the plan year.

|                                                                                                                                                                                                                                                             |   |   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....                                                                                                                       | 1 | 0 |
| <b>2</b> Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):<br><br>EIN(s): 39-0989781 |   |   |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                            |   |   |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year .....                                                                                                                            | 3 |   |

|         |                                                                                                                                                                        |
|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.) |
|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                             |                              |                             |                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                                                                                                                        |                              |                             |                              |
| <b>5</b> 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 ruling letter granting the waiver. Date: Month _____ Day _____ Year _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                             |                              |
| <b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....                                                                                                                                                                                                              | 6a                           |                             |                              |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                  | 6b                           |                             |                              |
| <b>c</b> Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....                                                                                                                                                                                                             | 6c                           |                             |                              |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                                                                                                                               |                              |                             |                              |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>8</b> If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? .....                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|          |            |
|----------|------------|
| Part III | Amendments |
|----------|------------|

|                                                                                                                                                                                                                            |                                   |                                   |                               |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| <b>9</b> If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|         |                                                                                                                                            |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Part IV | ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</b> If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

Schedule R (Form 5500) 2020  
v. 200204

**Part V Additional Information for Multiemployer Defined Benefit Pension Plans**

**13** Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

- 14** Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

**a** The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ last contributing employer ☐ alternative ☐ reasonable approximation (see instructions for required attachment).....

**b** The plan year immediately preceding the current plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....

**c** The second preceding plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....

|            |  |
|------------|--|
| <b>14a</b> |  |
| <b>14b</b> |  |
| <b>14c</b> |  |

- 15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

**a** The corresponding number for the plan year immediately preceding the current plan year.....

**b** The corresponding number for the second preceding plan year.....

|            |  |
|------------|--|
| <b>15a</b> |  |
| <b>15b</b> |  |

- 16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

**a** Enter the number of employers who withdrew during the preceding plan year.....

**b** If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....

|            |  |
|------------|--|
| <b>16a</b> |  |
| <b>16b</b> |  |

- 17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. .... ☐

**Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans**

- 18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment..... ☐

- 19** If the total number of participants is 1,000 or more, complete lines (a) through (c)

**a** Enter the percentage of plan assets held as:  
 Stock: \_\_\_\_\_% Investment-Grade Debt: \_\_\_\_\_% High-Yield Debt: \_\_\_\_\_% Real Estate: \_\_\_\_\_% Other: \_\_\_\_\_%

**b** Provide the average duration of the combined investment-grade and high-yield debt:  
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

**c** What duration measure was used to calculate line 19(b)?  
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): \_\_\_\_\_

- 20 PBGC missed contribution reporting requirements.** If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

**a** Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? ☐ Yes ☐ No

**b** If line 20a is "Yes," 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 \_\_\_\_\_

Financial Statements  
and Supplemental Schedules

Coffee Medical Group, LLC  
dba Unity Medical Center  
401(k) Plan

*As of December 31, 2020 and 2019, and  
for the year ended December 31, 2020  
with Independent Auditor's Report*

Coffee Medical Group, LLC  
dba Unity Medical Center 401(k) Plan

Financial Statements  
and Supplemental Schedules

As of December 31, 2020 and 2019, and  
for the year ended December 31, 2020

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## Independent Auditor's Report

Plan Administrator  
Coffee Medical Group, LLC  
dba Unity Medical Center 401(k) Plan

### Report on the Financial Statements

We were engaged to audit the accompanying financial statements of the Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan (the Plan), which comprise the statements of net assets available for benefits as of December 31, 2020 and 2019, and the related statement of changes in net assets available for benefits for the year ended December 31, 2020, and the related notes to the financial statements.

### Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

### Basis for Disclaimer of Opinion

As permitted by Section 2520.103-8 of the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA), the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by Transamerica Life Insurance Company, the custodian, except for comparing the information with the related information included in the financial statements. We have been informed by the Plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the custodian as of December 31, 2020 and 2019, and for the year ended December 31, 2020, that the information provided to the Plan administrator by the custodian is complete and accurate.

### Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient, appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Plan Administrator  
Coffee Medical Group, LLC  
dba Unity Medical Center 401(k) Plan

**Other Matter**

The supplemental schedules of Delinquent Participant Contributions and Assets (Held at End of Year) as of and for the year ended December 31, 2020, are required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

**Report on Form and Content in Compliance with DOL Rules and Regulations**

The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the custodian have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

*Coulter & Justus, P.C.*

*Coulter & Justus, P.C.*

October 14, 2021  
Knoxville, Tennessee

# Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

## Statements of Net Assets Available for Benefits

|                                    | December 31         |                     |
|------------------------------------|---------------------|---------------------|
|                                    | 2020                | 2019                |
| <b>Assets</b>                      |                     |                     |
| Investments:                       |                     |                     |
| Investments at fair value          | \$ 1,487,462        | \$ 1,254,570        |
| Investment at contract value       | 167,344             | 145,311             |
| Total investments                  | 1,654,806           | 1,399,881           |
| Receivables:                       |                     |                     |
| Participant cash contributions     | 5,206               | 13,526              |
| Notes receivable from participants | 26,560              | 40,850              |
| Total receivables                  | 31,766              | 54,376              |
| Total assets                       | 1,686,572           | 1,454,257           |
| <b>Liabilities</b>                 |                     |                     |
| Excess contributions payable       | 10,502              | -                   |
| Net assets available for benefits  | <u>\$ 1,676,070</u> | <u>\$ 1,454,257</u> |

*See accompanying Notes to Financial Statements.*

Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

Statement of Changes in Net Assets Available for Benefits

Year ended December 31, 2020

**Additions**

|                                                       |                |
|-------------------------------------------------------|----------------|
| Interest income from stable value advantage option    | \$ 2,547       |
| Interest income on notes receivable from participants | 1,948          |
| Participant cash contributions                        | <u>177,117</u> |
| Total additions                                       | <u>181,612</u> |

**Deductions**

|                                                |                |
|------------------------------------------------|----------------|
| Benefits paid to participants                  | 201,909        |
| Administrative expenses to parties-in-interest | <u>6,214</u>   |
| Total deductions                               | <u>208,123</u> |

|                |          |
|----------------|----------|
| Net deductions | (26,511) |
|----------------|----------|

|                                               |                |
|-----------------------------------------------|----------------|
| Net appreciation in fair value of investments | <u>248,324</u> |
| Net increase                                  | <u>221,813</u> |

|                                                        |           |
|--------------------------------------------------------|-----------|
| Net assets available for benefits at beginning of year | 1,454,257 |
|--------------------------------------------------------|-----------|

|                                                  |                            |
|--------------------------------------------------|----------------------------|
| Net assets available for benefits at end of year | <u><u>\$ 1,676,070</u></u> |
|--------------------------------------------------|----------------------------|

*See accompanying Notes to Financial Statements.*

# Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

## Notes to Financial Statements

December 31, 2020

### **1. Description of the Plan**

The following description of the Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

#### **General**

The Plan is a defined contribution plan available to eligible employees of Coffee Medical Group, LLC dba Unity Medical Center (the Plan Sponsor). Participation in the Plan is strictly voluntary, and employees can elect to participate on the first day of January or July after attaining age 18 and completing 500 hours of eligible service in a six-month period. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Sponsor is responsible for the administration of the Plan and has entrusted the maintenance of records and the day-to-day administration to TAG Resources, LLC (TAG) who processes transactions through Transamerica Life Insurance Company (Transamerica), the custodian.

#### **Contributions**

Participating employees may defer 401(k) contributions up to 90% of their pre-tax annual compensation, as defined in the Plan. In addition, participants who have attained the age of 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans (rollovers). Participants direct the investment of their contributions into various investment options offered by the Plan as listed in the schedule of assets (held at end of year). Participants can change the investment options previously elected at any time. Participant contributions have not always been remitted to the Plan in a timely manner; the Plan Sponsor makes a contribution for the lost earnings to the Plan, if required.

The Plan Sponsor may make discretionary matching or qualified nonelective contributions. During 2020, the Plan Sponsor did not make any such contributions.

Contributions are subject to certain Internal Revenue Service (IRS) limitations. Receivables from the Plan Sponsor for contributions are unsecured.

#### **Participant Accounts**

Each participant's account is credited with the participant's contributions, the Plan Sponsor's discretionary matching and qualified nonelective contributions and Plan earnings or losses. Participant accounts are charged with an allocation of administrative expenses that are paid by the Plan. Allocations are based on participant earnings, account balances or specific participant transactions, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### 1. Description of the Plan (continued)

##### Vesting

Participants are immediately vested in their voluntary contributions and discretionary qualified nonelective contributions plus actual earnings on these contributions. Vesting in the Plan Sponsor's discretionary matching contributions, if any, plus related earnings thereon is based on years of vesting service in which the participants complete 1,000 hours of service, as follows:

| <u>Years of Service</u> | <u>Vesting Percentage</u> |
|-------------------------|---------------------------|
| Less than 1             | 0%                        |
| 1 but less than 2       | 20%                       |
| 2 but less than 3       | 50%                       |
| 3 or more               | 100%                      |

##### Notes Receivable from Participants

Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their vested account balance. The loans are secured by the balance in the participant's account. The loan interest rate is set at 1% above the prime rate, as defined. Principal and interest are paid ratably through payroll deductions.

##### Payment of Benefits

If the participant's vested benefit in the Plan does not exceed \$1,000 at the time of termination of employment, the participant's benefit may be distributed in a single lump-sum payment as soon as administratively feasible. If the participant's vested benefit in the Plan exceeds \$1,000 but is less than \$5,000, the participant's benefit must be distributed in a single lump-sum payment or rolled over into another individual retirement account. If the participant's vested benefit in the Plan exceeds \$5,000 at the time of termination of employment, the participant may elect to either maintain their account in the Plan, receive a lump-sum distribution or rollover their account balance into another individual retirement account. Participants may also withdraw their vested account balances at any time on or after the age of 59½, or upon retirement, death or disability.

#### 2. Significant Accounting Policies

##### Basis of Accounting

The financial statements of the Plan are prepared on the accrual basis of accounting.

##### Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures and changes therein. Accordingly, actual results could differ from those estimates.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### **2. Significant Accounting Policies (continued)**

##### **Investment Valuation and Income Recognition**

The Plan's investments are reported at fair value except for its benefit-responsive investment contract, which is valued at contract value (Note 5). Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan Sponsor's management determines the Plan's valuation policies utilizing information provided by Transamerica. See Note 4 for a discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold, as well as held, during the year.

##### **Notes Receivable from Participants**

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed as incurred. No allowance for credit losses has been recorded as of December 31, 2020 or 2019. If a participant ceases to make scheduled repayments and the Plan administrator deems the note receivable to be in default, the note receivable balance is reduced and a benefit payment recorded.

##### **Excess Contributions Payable**

Amounts payable to participants totaling \$10,502 as of December 31, 2020, for contributions in excess of amounts allowed by the IRS are recorded as a liability with a corresponding reduction to contributions. The Plan distributed the excess contributions to the applicable participants during 2021.

##### **Benefits Paid to Participants**

Benefits are recorded when paid.

##### **Administrative Expenses**

Certain expenses of maintaining the Plan are paid by the Plan, unless otherwise paid by the Plan Sponsor. Expenses paid by the Plan Sponsor are excluded from these financial statements. Fees related to the administration of notes receivable from participants are charged directly to the participant's account and are included in administrative expenses. Investment related expenses are included in net appreciation (depreciation) in fair value of investments.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### 2. Significant Accounting Policies (continued)

##### Subsequent Events

The Plan has evaluated subsequent events through October 14, 2021, the date the financials were available to be issued.

Effective January 1, 2021, the Plan Sponsor added a matching contribution equal to 100% of a participant's contribution up to 3% of the participant's compensation. Vesting in the matching contribution will be earned in 20% increments over 5 years.

#### 3. Certified Information (Unaudited)

Transamerica holds the Plan's investment assets and executes transactions therein. Financial information relating to those assets, including investments and notes receivable from participants, is included in the accompanying financial statements based on information supplied to the Plan administrator and certified as complete and accurate by Transamerica. That information, which has not been audited by independent auditors, is summarized below.

The value of investments is as follows as of December 31:

|                              | <b>2020</b>               | <b>2019</b>               |
|------------------------------|---------------------------|---------------------------|
| Investments at fair value    | <b>\$1,487,462</b>        | \$1,254,570               |
| Investment at contract value | <b>167,344</b>            | 145,311                   |
| Total investments            | <b><u>\$1,654,806</u></b> | <b><u>\$1,399,881</u></b> |

Notes receivable from participants total \$26,560 and \$40,850 as of December 31, 2020 and 2019, respectively. Interest earned on notes receivable from participants totaled \$1,948 in 2020.

Net appreciation in fair value of investments totaled \$248,324 in 2020. Interest income from the stable value advantage option totaled \$2,547 in 2020.

The Plan has one investment representing greater than 20% of net assets available for benefits as of December 31, 2020 and 2019.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### 4. Fair Value Measurements

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

- Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets the Plan can access.
- Level 2 Inputs to the methodology include:
  - Quoted prices for similar assets or liabilities in active markets;
  - Quoted prices for identical or similar assets or liabilities in inactive markets;
  - Inputs other than quoted prices that are observable for the asset or liability;
  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means.If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value:

*Pooled separate accounts:* Valued at the net asset value (NAV) which equals the number of shares of the respective underlying fund, multiplied by the closing NAV per share quoted by that fund. The NAV is used as a practical expedient to estimate fair value.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### 4. Fair Value Measurements (continued)

Classification within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. The following table sets forth by level, within the fair value hierarchy, the Plan's investments as of December 31:

|                            | Level 1 | Level 2 | Level 3 | Total              |
|----------------------------|---------|---------|---------|--------------------|
| <b>2020:</b>               |         |         |         |                    |
| Pooled separate accounts*  | \$ —    | \$ —    | \$ —    | <b>\$1,487,462</b> |
| <b>2019:</b>               |         |         |         |                    |
| Pooled separate accounts * | \$ —    | \$ —    | \$ —    | <b>\$1,254,570</b> |

\* - In accordance with Subtopic 820-10, the Plan's interest in the pooled separate accounts is measured at fair value using the NAV per share (or its equivalent) practical expedient and has not been classified in the fair value hierarchy. The NAV is determined by Transamerica and is based on the fair value of the underlying assets held by the funds. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the line items presented in the statements of net assets available for benefits.

#### *Fair value of Investments that use NAV*

The following table summarizes investments measuring at fair value based on NAV per share as of December 31:

| Investment Type             | Fair Value<br>2020 | Fair Value<br>2019 | Unfunded<br>Commitments | Redemption<br>Frequency | Redemption<br>Notice<br>for Period |
|-----------------------------|--------------------|--------------------|-------------------------|-------------------------|------------------------------------|
| Pooled separate<br>accounts | <b>\$1,487,462</b> | \$1,254,570        | None                    | Daily                   | Daily                              |

#### 5. Stable Value Advantage Option

The Plan invests in a fully benefit-responsive traditional investment contract held in the Transamerica Stable Value Advantage Option (Stable Value Advantage Option). The contributions are maintained in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. Transamerica is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. The effective rate of interest is established every January 1 and July 1 and is based on the daily balance, at a rate that is the daily equivalent of the effective annual rate of interest applicable for the six-month period. There is no stated minimum or maximum interest rate. The guaranteed investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### **5. Stable Value Advantage Option (continued)**

The contract meets the fully benefit-responsive investment criteria and therefore is reported at contract value. Contract value is the relevant measurement for fully benefit-responsive investment contracts, because it is the amount received by participants if they were to initiate permitted transactions under the terms of the Plan. Contract value, as reported to the Plan by Transamerica, represents contributions made under the contract, plus earnings, less participant withdrawals and expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

The Plan's ability to receive amounts due is dependent on the issuer's ability to meet its financial obligations. The issuer's ability to meet its contractual obligations may be affected by future economic and regulatory developments.

Certain events limit the ability of the Plan to transact at contract value with Transamerica. Such events include amendments to the Plan documents (including complete or partial plan termination or merger with another plan), changes to the Plan's prohibition on competing investment options or deletion of equity wash provisions, bankruptcy of the Plan Sponsor or other Plan Sponsor events that cause a significant withdrawal from the Plan, the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA or premature termination of the contract. The Plan administrator does not believe any events are probable of occurring that might limit the ability of the Plan to transact at contract value with the contract issuers and that also would limit the ability of the Plan to transact at contract value with the participants.

In addition, certain events allow the issuer to terminate the contract with the Plan and settle at an amount different from contract value. Such events include an uncured violation of the Plan's investment guidelines, a breach of material obligation under the contract, a material misrepresentation or a material amendment to the agreement without consent of the issuer.

#### **6. Related Party Transactions and Party-in-Interest Transactions**

Plan investments are in accounts of Transamerica; therefore, these transactions qualify as party-in-interest transactions. Notes receivable from participants and participant contributions are also considered to be party-in-interest transactions. Plan Sponsor contributions are considered to be party-in-interest and related party transactions.

#### **7. Plan Termination**

Although it has not expressed any intent to do so, the Plan Sponsor has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants will become 100% vested in their Plan Sponsor contributions.

## Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan

### Notes to Financial Statements (continued)

#### **8. Income Tax Status**

The Plan adopted a volume submitter plan which had received an advisory letter dated March 31, 2014, from the IRS which stated the plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code (IRC). Although the plan has been amended since receiving the advisory letter, the Plan administrator and the Plan's tax counsel believe the Plan is designed and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, believe the Plan is qualified, and the related trust is tax-exempt.

#### **9. Risks and Uncertainties**

The Plan invests in various investment securities, which are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term, and that such changes could materially affect participants' account balances and amounts reported in the statements of net assets available for benefits.

As a result of the coronavirus (COVID-19) pandemic, economic uncertainties have arisen which have resulted in significant volatility in the investment markets. The duration of the uncertainties and the ultimate financial effects on the Plan's investments cannot be reasonably estimated as of the date of these financial statements.

Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan  
Employer Identification Number: 46-0485169; Plan Number: 101

Schedule H, Line 4a - Schedule of Delinquent Participant Contributions (Unaudited)

Year ended December 31, 2020

|       |                                                        | Total that Constitute Nonexempt Prohibited Transactions     |                             |                                                                        |                                                                            | Total Fully Corrected Under Voluntary Fiduciary Correction Program and PTE 2002-51 |
|-------|--------------------------------------------------------|-------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Year  | Participant Contributions Transferred Late to the Plan | Check Here if Late Participant Loan Repayments are Included | Contributions Not Corrected | Contributions Corrected Outside Voluntary Fiduciary Correction Program | Contributions Pending Correction in Voluntary Fiduciary Correction Program |                                                                                    |
| 2015  | \$ 1,620                                               |                                                             | \$ 1,620                    | \$ -                                                                   | \$ -                                                                       | \$ -                                                                               |
| Total | <u>\$ 1,620</u>                                        |                                                             | <u>\$ 1,620</u>             | <u>\$ -</u>                                                            | <u>\$ -</u>                                                                | <u>\$ -</u>                                                                        |

Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan  
Employer Identification Number: 46-0485169; Plan Number: 101

Schedule H, Line 4i - Schedule of Assets (Held at End of Year) (Unaudited)

December 31, 2020

| Identity of Issue,<br>Borrower, Lessor or<br>Similar Party | Description of Investment, including<br>Maturity Date, Rate of Interest,<br>Collateral, Par or Maturity Value | Cost   | Current<br>Value           |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------|----------------------------|
| Investments at fair value:                                 |                                                                                                               |        |                            |
| *Transamerica Life Insurance Company                       | American Century Focused Global Growth                                                                        | (1) \$ | 20,082                     |
| *Transamerica Life Insurance Company                       | DFA Emerging Markets Core Equity                                                                              | (1)    | 22,987                     |
| *Transamerica Life Insurance Company                       | DFA US Small Cap Portfolio                                                                                    | (1)    | 9,315                      |
| *Transamerica Life Insurance Company                       | Eaton Vance Atlanta Cap SMID                                                                                  | (1)    | 56,120                     |
| *Transamerica Life Insurance Company                       | Eaton Vance High Income Opportunities                                                                         | (1)    | 316                        |
| *Transamerica Life Insurance Company                       | Goldman Sachs Bond                                                                                            | (1)    | 46,917                     |
| *Transamerica Life Insurance Company                       | JPMorgan US Equity                                                                                            | (1)    | 103,733                    |
| *Transamerica Life Insurance Company                       | Morgan Stanley Growth                                                                                         | (1)    | 73,977                     |
| *Transamerica Life Insurance Company                       | Principial Diversified Real Assets                                                                            | (1)    | 6,878                      |
| *Transamerica Life Insurance Company                       | State Street International Index                                                                              | (1)    | 44,388                     |
| *Transamerica Life Insurance Company                       | State Street Russell Small Cap Index                                                                          | (1)    | 72,191                     |
| *Transamerica Life Insurance Company                       | State Street S&P Mid Cap Index                                                                                | (1)    | 25,244                     |
| *Transamerica Life Insurance Company                       | State Street U.S. Bond Index Fund                                                                             | (1)    | 32,548                     |
| *Transamerica Life Insurance Company                       | State Street Target Retirement Inc                                                                            | (1)    | 11,345                     |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2020                                                                           | (1)    | 19,579                     |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2025                                                                           | (1)    | 256,304                    |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2030                                                                           | (1)    | 29,691                     |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2035                                                                           | (1)    | 180,006                    |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2040                                                                           | (1)    | 355,002                    |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2045                                                                           | (1)    | 21,800                     |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2050                                                                           | (1)    | 3,352                      |
| *Transamerica Life Insurance Company                       | T Rowe Price Equity Income                                                                                    | (1)    | 16,022                     |
| *Transamerica Life Insurance Company                       | Transamerica International Equity Fund                                                                        | (1)    | 21,559                     |
| *Transamerica Life Insurance Company                       | TA Vanguard Total Stk Market Index                                                                            | (1)    | 34,771                     |
| *Transamerica Life Insurance Company                       | Transamerica Partners Stock Index                                                                             | (1)    | 23,335                     |
| Total investments at fair value                            |                                                                                                               |        | <u>1,487,462</u>           |
| Investment at contract value:                              |                                                                                                               |        |                            |
| *Transamerica Life Insurance Company                       | Transamerica Stable Value Advantage Option                                                                    | (1)    | 167,344                    |
| *Participant notes receivable                              | Loans bearing interest at rates ranging from<br>5.5% to 6.5%, to be repaid through 2024                       |        | 26,560                     |
| Total assets held for investment purposes at end of year   |                                                                                                               |        | <u><u>\$ 1,681,366</u></u> |

\* Represents a party-in-interest to the Plan.

(1) Cost information has been omitted since these investments are participant-directed.

Coffee Medical Group, LLC dba Unity Medical Center 401(k) Plan  
Employer Identification Number: 46-0485169; Plan Number: 101

Schedule H, Line 4i - Schedule of Assets (Held at End of Year) (Unaudited)

December 31, 2020

| Identity of Issue,<br>Borrower, Lessor or<br>Similar Party | Description of Investment, including<br>Maturity Date, Rate of Interest,<br>Collateral, Par or Maturity Value | Cost   | Current<br>Value |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------|------------------|
| Investments at fair value:                                 |                                                                                                               |        |                  |
| *Transamerica Life Insurance Company                       | American Century Focused Global Growth                                                                        | (1) \$ | 20,082           |
| *Transamerica Life Insurance Company                       | DFA Emerging Markets Core Equity                                                                              | (1)    | 22,987           |
| *Transamerica Life Insurance Company                       | DFA US Small Cap Portfolio                                                                                    | (1)    | 9,315            |
| *Transamerica Life Insurance Company                       | Eaton Vance Atlanta Cap SMID                                                                                  | (1)    | 56,120           |
| *Transamerica Life Insurance Company                       | Eaton Vance High Income Opportunities                                                                         | (1)    | 316              |
| *Transamerica Life Insurance Company                       | Goldman Sachs Bond                                                                                            | (1)    | 46,917           |
| *Transamerica Life Insurance Company                       | JPMorgan US Equity                                                                                            | (1)    | 103,733          |
| *Transamerica Life Insurance Company                       | Morgan Stanley Growth                                                                                         | (1)    | 73,977           |
| *Transamerica Life Insurance Company                       | Principial Diversified Real Assets                                                                            | (1)    | 6,878            |
| *Transamerica Life Insurance Company                       | State Street International Index                                                                              | (1)    | 44,388           |
| *Transamerica Life Insurance Company                       | State Street Russell Small Cap Index                                                                          | (1)    | 72,191           |
| *Transamerica Life Insurance Company                       | State Street S&P Mid Cap Index                                                                                | (1)    | 25,244           |
| *Transamerica Life Insurance Company                       | State Street U.S. Bond Index Fund                                                                             | (1)    | 32,548           |
| *Transamerica Life Insurance Company                       | State Street Target Retirement Inc                                                                            | (1)    | 11,345           |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2020                                                                           | (1)    | 19,579           |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2025                                                                           | (1)    | 256,304          |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2030                                                                           | (1)    | 29,691           |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2035                                                                           | (1)    | 180,006          |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2040                                                                           | (1)    | 355,002          |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2045                                                                           | (1)    | 21,800           |
| *Transamerica Life Insurance Company                       | State Street Target Retirement 2050                                                                           | (1)    | 3,352            |
| *Transamerica Life Insurance Company                       | T Rowe Price Equity Income                                                                                    | (1)    | 16,022           |
| *Transamerica Life Insurance Company                       | Transamerica International Equity Fund                                                                        | (1)    | 21,559           |
| *Transamerica Life Insurance Company                       | TA Vanguard Total Stk Market Index                                                                            | (1)    | 34,771           |
| *Transamerica Life Insurance Company                       | Transamerica Partners Stock Index                                                                             | (1)    | 23,335           |
| Total investments at fair value                            |                                                                                                               |        | 1,487,462        |
| Investment at contract value:                              |                                                                                                               |        |                  |
| *Transamerica Life Insurance Company                       | Transamerica Stable Value Advantage Option                                                                    | (1)    | 167,344          |
| *Participant notes receivable                              | Loans bearing interest at rates ranging from<br>5.5% to 6.5%, to be repaid through 2024                       |        | 26,560           |
| Total assets held for investment purposes at end of year   |                                                                                                               |        | \$ 1,681,366     |

\* Represents a party-in-interest to the Plan.

(1) Cost information has been omitted since these investments are participant-directed.