

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110
1210-0089

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

- A** This return/report is for: a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- B** This return/report is the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** Check box if filing under: Form 5558 automatic extension DFVC program
 special extension (enter description)
- D** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>INNOVATIVE MEDICAL HEALTHCARE, PC DEFINED BENEFIT</u>	1b Three-digit plan number (PN) ▶	<u>001</u>
	1c Effective date of plan	<u>01/01/2014</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>INNOVATIVE MEDICAL HEALTHCARE, PC</u> <u>11 HEMLOCK LANE</u> <u>ROSLYN HEIGHTS, NY 11577</u>	2b Employer Identification Number (EIN)	<u>45-5026526</u>
	2c Sponsor's telephone number	<u>516-633-1439</u>
	2d Business code (see instructions)	<u>621111</u>
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5a Total number of participants at the beginning of the plan year	5a	<u>3</u>
b Total number of participants at the end of the plan year	5b	<u>3</u>
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c	
d(1) Total number of active participants at the beginning of the plan year	5d(1)	<u>3</u>
d(2) Total number of active participants at the end of the plan year	5d(2)	<u>3</u>
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	<u>0</u>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/07/2022</u>	<u>USMAN SALEEM</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Yes No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information			
7		(a) Beginning of Year	(b) End of Year
7	Plan Assets and Liabilities		
a	Total plan assets	7a 1440200	1864444
b	Total plan liabilities	7b 0	0
c	Net plan assets (subtract line 7b from line 7a)	7c 1440200	1864444
8		(a) Amount	(b) Total
a	Contributions received or receivable from:		
(1)	Employers	8a(1) 300000	
(2)	Participants	8a(2) 0	
(3)	Others (including rollovers)	8a(3) 0	
b	Other income (loss)	8b 131798	
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	431798
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d 0	
e	Certain deemed and/or corrective distributions (see instructions) .	8e 0	
f	Administrative service providers (salaries, fees, commissions)	8f 0	
g	Other expenses	8g 7554	
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	7554
i	Net income (loss) (subtract line 8h from line 8c)	8i	424244
j	Transfers to (from) the plan (see instructions)	8j	

Part IV Plan Characteristics	
9a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1A 3D
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions				
10		Yes	No	Amount
a	During the plan year: Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a	X	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b	X	
c	Was the plan covered by a fidelity bond?	10c	X	186445
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d	X	
e	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e	X	
f	Has the plan failed to provide any benefit when due under the plan?	10f	X	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	X	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i		

Part VI Pension Funding Compliance

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

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

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

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

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

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

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

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

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

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

Part VII Plan Terminations and Transfers of Assets

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

If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? Yes No

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

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

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	<small>OMB No. 1210-0110</small> 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

▶ **Round off amounts to nearest dollar.**
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>INNOVATIVE MEDICAL HEALTHCARE, PC DEFINED BENEFIT</u>	B Three-digit plan number (PN) ▶	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>INNOVATIVE MEDICAL HEALTHCARE, PC</u>	D Employer Identification Number (EIN) <u>45-5026526</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2021</u>		
2	Assets:		
	a Market value	2a	<u>1563595</u>
	b Actuarial value	2b	<u>1563595</u>
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment	<u>0</u>	<u>0</u>
	b For terminated vested participants	<u>0</u>	<u>0</u>
	c For active participants	<u>3</u>	<u>1341035</u>
	d Total	<u>3</u>	<u>1348868</u>
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b	
5	Effective interest rate	5	<u>5.41 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>200647</u>
	b Expected plan-related expenses	6b	<u>7554</u>
	c Total (line 6a + line 6b)	6c	<u>208201</u>

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

SIGN HERE		
	Signature of actuary	<u>10/08/2022</u> Date
	<u>CHARLES STIPELMAN, FSPA</u> Type or print name of actuary	<u>20-02286</u> Most recent enrollment number
	<u>NATIONAL PROFESSIONAL PLANNING GRO</u> Firm name	<u>732-758-1577</u> Telephone number (including area code)
	<u>494 SYCAMORE AVENUE - SUITE 100</u> <u>SHREWSBURY, NJ 07702</u> Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	0	0
10	Interest on line 9 using prior year's actual return of _____%	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		136502
	b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.94</u> %		8108
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
	c Total available at beginning of current plan year to add to prefunding balance		144610
	d Portion of (c) to be added to prefunding balance		144610
12	Other reductions in balances due to elections or deemed elections	0	144610
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages			
14	Funding target attainment percentage	14	115.91 %
15	Adjusted funding target attainment percentage	15	115.91 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	137.14 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls		18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
09/07/2021	50000						
09/12/2022	250000						
			Totals ▶	18(b)	300000	18(c)	0

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:	
	a Contributions allocated toward unpaid minimum required contributions from prior years	19a 0
	b Contributions made to avoid restrictions adjusted to valuation date	19b 0
	c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c 291381
20	Quarterly contributions and liquidity shortfalls:	
	a Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c If line 20a is "Yes," see instructions and complete the following table as applicable:	
Liquidity shortfall as of end of quarter of this plan year		
(1) 1st	(2) 2nd	(3) 3rd
		(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:	1st segment: 3.32 %	2nd segment: 4.79 %	3rd segment: 5.47 %	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code) **21b** 0

22 Weighted average retirement age **22** 62

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment..... Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28**

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... **29** 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6c).....	31a	208201
b Excess assets, if applicable, but not greater than line 31a	31b	208201

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment.....	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount..... **33**

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... **34** 0

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0

36 Additional cash requirement (line 34 minus line 35) **36** 0

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 291381

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36)	38a	291381
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances.....	38b	0

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0

40 Unpaid minimum required contributions for all years **40** 0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
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Short Form Annual Return/Report of Small Employee Benefit Plan

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▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110
1210-0099

2021

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B This return/report is the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)

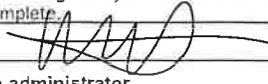
C Check box if filing under: Form 5558 automatic extension DFVC program
 special extension (enter description)

D If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

1a Name of plan Innovative Medical Healthcare, PC Defined Benefit	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan 01/01/2014
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Innovative Medical Healthcare, PC 11 Hemlock Lane Roslyn Heights NY 11577	2b Employer Identification Number (EIN) 45-5026526
	2c Sponsor's telephone number (516) 633-1439
	2d Business code (see instructions) 621111
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN
	4d PN
5a Total number of participants at the beginning of the plan year	5a 3
b Total number of participants at the end of the plan year	5b 3
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c
d(1) Total number of active participants at the beginning of the plan year	5d(1) 3
d(2) Total number of active participants at the end of the plan year	5d(2) 3
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e 0

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Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	<input checked="" type="checkbox"/>		<u>x 10/7/22</u>	Usman Saleem
		Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE				
		Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

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Part II Basic Plan Information—enter all requested information

1a Name of plan Innovative Medical Healthcare, PC Defined Benefit		1b Three-digit plan number (PN) ▶	001
		1c Effective date of plan	01/01/2014
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Innovative Medical Healthcare, PC 11 Hemlock Lane Roslyn Heights NY 11577		2b Employer Identification Number (EIN)	45-5026526
		2c Sponsor's telephone number (516) 633-1439	
		2d Business code (see instructions)	621111
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name		4b EIN	
		4d PN	
5a Total number of participants at the beginning of the plan year		5a	3
b Total number of participants at the end of the plan year		5b	3
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		5c	
d(1) Total number of active participants at the beginning of the plan year		5d(1)	3
d(2) Total number of active participants at the end of the plan year		5d(2)	3
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		5e	0

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE			Usman Saleem
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2021)
v.210624

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Yes No
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____ (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1,440,200	1,864,444
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	1,440,200	1,864,444
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	300,000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	131,798	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		431,798
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	0	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	7,554	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		7,554
i Net income (loss) (subtract line 8h from line 8c)	8i		424,244
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 1A 3D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		186,445
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h			
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

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

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 200,647

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

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

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

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

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

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

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

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

Part VII Plan Terminations and Transfers of Assets

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

If "Yes," enter the amount of any plan assets that reverted to the employer this year **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? Yes No

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

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

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

▶ **Round off amounts to nearest dollar.**

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

A Name of plan Innovative Medical Healthcare, PC Defined Benefit	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Innovative Medical Healthcare, PC	D Employer Identification Number (EIN) 45-5026526	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information	
1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2021</u>
2	Assets:
a	Market value 2a 1,563,595
b	Actuarial value 2b 1,563,595
3	Funding target/participant count breakdown
a	For retired participants and beneficiaries receiving payment..... (1) 0 (2) 0 (3) 0
b	For terminated vested participants..... (1) 0 (2) 0 (3) 0
c	For active participants (1) 3 (2) 1,341,035 (3) 1,348,868
d	Total (1) 3 (2) 1,341,035 (3) 1,348,868
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>
a	Funding target disregarding prescribed at-risk assumptions 4a
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor 4b
5	Effective interest rate 5 5.41 %
6	Target normal cost.....
a	Present value of current plan year accruals 6a 200,647
b	Expected plan-related expenses 6b 7,554
c	Total (line 6a + line 6b) 6c 208,201

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

SIGN HERE		10/08/2022
	Signature of actuary	Date
	Charles Stipelman, FSPA	20-02286
	Type or print name of actuary	Most recent enrollment number
	National Professional Planning Gro	(732) 758-1577
	Firm name	Telephone number (including area code)
	494 Sycamore Avenue - Suite 100	
	Address of the firm	
	Shrewsbury NJ 07702	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	0	0
10	Interest on line 9 using prior year's actual return of _____%	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		136502
	b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.94</u> %		8108
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
	c Total available at beginning of current plan year to add to prefunding balance		144610
	d Portion of (c) to be added to prefunding balance		144610
12	Other reductions in balances due to elections or deemed elections	0	144610
13	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages			
14	Funding target attainment percentage	14	115.91%
15	Adjusted funding target attainment percentage	15	115.91%
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	137.14%
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
09/07/2021	50,000				
09/12/2022	250,000				
Totals ▶			18(b)	300,000	18(c)
					0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:			
a	Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b	Contributions made to avoid restrictions adjusted to valuation date	19b	0
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	291,381
20	Quarterly contributions and liquidity shortfalls:		
	a Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	c If line 20a is "Yes," see instructions and complete the following table as applicable:		
Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:	1st segment: 3.32 %	2nd segment: 4.79 %	3rd segment: 5.47 %	<input type="checkbox"/> N/A, full yield curve used
-------------------------	------------------------	------------------------	------------------------	---

b Applicable month (enter code) **21b** 0

22 Weighted average retirement age **22** 62

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28**

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6c).....	31a	208,201
b Excess assets, if applicable, but not greater than line 31a	31b	208,201

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment.....	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33**

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... **34** 0

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0

36 Additional cash requirement (line 34 minus line 35) **36** 0

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 291,381

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36)	38a	291,381
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0

40 Unpaid minimum required contributions for all years **40** 0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2021)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan
EID#: 45-5026526 / 001

Part V : SUMMARY OF PLAN PROVISIONS

Eligibility:	Full time employees who have attained the age of 21 and have completed 1 year of service. Entry is on the January 1 st nearest the completion of the requirements.
Vesting:	20% after 2 years, 20% per year thereafter.
Normal Retirement:	The attainment of age 62.
Benefit Formula:	10% of average compensation per year of participation
Compensation:	Three (3) highest consecutive years.
Accrued Benefit:	Unit credit
Normal Form of Benefit:	Monthly benefits are payable on a life annuity basis.
Alternative Forms :	Actuarial equivalence of Normal Form – Lump Sum, Period Certain, Joint and survivor
Death Benefit:	Fully vested present value of accrued benefit.
Actuarial Equivalence:	
Interest:	5.5% pre and post retirement
Pre-Retirement Mortality:	None
Post Retirement Mortality :	1994 Group Annuity Reserving (GAR), unisex

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2021)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan
EID#: 45-5026526 / 001

PART V : STATEMENT OF ACTUARIAL ASSUMPTIONS AND METHODS

Interest :	0.92%, 2.62%, 3.29% (IRC 404) 3.32%, 4.79%, 5.47% (IRC 430, AFTAP) 5.41% (effective rate)
ARPA.....	Waived for 2021 plan year
Mortality :	Prescribed, combined – 2021
Insurance :	None
Turnover :	None assumed
Salary scale :	None assumed
Expense factor :	None assumed
Normal retirement :	On normal retirement date
Non prescribed assumptions :	None
Valuation date :	Last day of plan year
Cost method :	Unit credit

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2021)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan
EID#: 45-5026526 / 001

PART V , Line 22: WTD AVE RET AGE

All participants assumed to retire at normal retirement age of 62

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2021)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan

EID#: 13-3687641 / 001

PART V , Line 26: SCHEDULE OF ACTIVE PARTICIPANTS

Service Ages	0-4	5-9	10-14	15-19	20-24	25-29	30+
Under 21							
21-24							
25-29							
30-34							
35-39		1					
40-44				1			
45-49				1			
50-54							
55-59							
60-64							
65+							

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2021)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan

EID#: 13-3687641 / 001

PART V , Line 26: SCHEDULE OF ACTIVE PARTICIPANTS

Service Ages	0-4	5-9	10-14	15-19	20-24	25-29	30+
Under 21							
21-24							
25-29							
30-34							
35-39		1					
40-44				1			
45-49				1			
50-54							
55-59							
60-64							
65+							