

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2022</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2022 or fiscal plan year beginning <u>01/01/2022</u> and ending <u>12/31/2022</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> 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	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)
D If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. <input type="checkbox"/>	

Part II Basic Plan Information —enter all requested information													
1a Name of plan INNOVATIVE MEDICAL HEALTHCARE, PC DEFINED BENEFIT	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> 1b Three-digit plan number (PN) ► </td> <td style="width: 40%; text-align: center; padding: 5px;">001</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> 1c Effective date of plan <div style="text-align: right;">01/01/2014</div> </td> </tr> </table>	1b Three-digit plan number (PN) ►	001	1c Effective date of plan <div style="text-align: right;">01/01/2014</div>									
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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	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> 2b Employer Identification Number (EIN) <u>45-5026526</u> </td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 5px;"> 2c Sponsor's telephone number <div style="text-align: right;">516-633-1439</div> </td> <td></td> </tr> <tr> <td style="padding: 5px;"> 2d Business code (see instructions) <div style="text-align: right;">621111</div> </td> <td></td> </tr> </table>	2b Employer Identification Number (EIN) <u>45-5026526</u>		2c Sponsor's telephone number <div style="text-align: right;">516-633-1439</div>		2d Business code (see instructions) <div style="text-align: right;">621111</div>							
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2d Business code (see instructions) <div style="text-align: right;">621111</div>													
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> 3b Administrator's EIN </td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 5px;"> 3c Administrator's telephone number </td> <td></td> </tr> </table>	3b Administrator's EIN		3c Administrator's telephone number									
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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	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> 4b EIN </td> <td style="width: 40%;"></td> </tr> <tr> <td style="padding: 5px;"> 4d PN </td> <td></td> </tr> </table>	4b EIN		4d PN									
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5a Total number of participants at the beginning of the plan year..... b Total number of participants at the end of the plan year c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) d(1) Total number of active participants at the beginning of the plan year d(2) Total number of active participants at the end of the plan year..... e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; text-align: right; padding: 5px;">5a</td> <td style="width: 40%; text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="text-align: right; padding: 5px;">5b</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="text-align: right; padding: 5px;">5c</td> <td style="text-align: center; padding: 5px;"></td> </tr> <tr> <td style="text-align: right; padding: 5px;">5d(1)</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="text-align: right; padding: 5px;">5d(2)</td> <td style="text-align: center; padding: 5px;">3</td> </tr> <tr> <td style="text-align: right; padding: 5px;">5e</td> <td style="text-align: center; padding: 5px;">0</td> </tr> </table>	5a	3	5b	3	5c		5d(1)	3	5d(2)	3	5e	0
5a	3												
5b	3												
5c													
5d(1)	3												
5d(2)	3												
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	Filed with authorized/valid electronic signature.	03/14/2023	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

- 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	1864444	1744374
b Total plan liabilities.....	7b	0	0
c Net plan assets (subtract line 7b from line 7a).....	7c	1864444	1744374
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers.....	8a(1)	252270	
(2) Participants.....	8a(2)	0	
(3) Others (including rollovers).....	8a(3)	0	
b Other income (loss).....	8b	-360562	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	8c		-108292
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	11778	
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		11778
i Net income (loss) (subtract line 8h from line 8c).....	8i		-120070
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		174438
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** 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? (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 2022 This Form is Open to Public Inspection
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For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

▶ **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>2022</u>	
2 Assets:	
a Market value.....	2a <u>1492104</u>
b Actuarial value	2b <u>1492104</u>
3 Funding target/participant count breakdown	
a For retired participants and beneficiaries receiving payment	(1) Number of participants <u>0</u> (2) Vested Funding Target <u>0</u> (3) Total Funding Target <u>0</u>
b For terminated vested participants.....	<u>0</u> <u>0</u> <u>0</u>
c For active participants.....	<u>3</u> <u>1464251</u> <u>1469524</u>
d Total	<u>3</u> <u>1464251</u> <u>1469524</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>5.84 %</u>
6 Target normal cost	
a Present value of current plan year accruals.....	6a <u>260833</u>
b Expected plan-related expenses	6b <u>11778</u>
c Total (line 6a + line 6b)	6c <u>272611</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		<u>04/26/2023</u>
	Signature of actuary	Date
<u>CHARLES STIPELMAN, FSPA</u>	Type or print name of actuary	<u>23-02286</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).....		275303
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 _____ 5.41 %.....		14894
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.....		290197
d Portion of (c) to be added to prefunding balance.....		290197
12 Other reductions in balances due to elections or deemed elections	0	290197
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	101.53 %
15 Adjusted funding target attainment percentage	15	101.53 %
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	%
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
02/23/2023	250000				
02/26/2023	2270				
			Totals ►	18(b)	252270
				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 250031
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: 4.75 %	2nd segment: 5.18 %	3rd segment: 5.92 %	<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)	<input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
26 Demographic and benefit information		
a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ...	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	27	

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years.....	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6c).....	31a	272611	
b Excess assets, if applicable, but not greater than line 31a	31b	22580	
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	250031	
	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	250031	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	250031	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	0	
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 the American Rescue Plan Act of 2021 (See Instructions)

41 If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies. <input type="checkbox"/> 2019 <input type="checkbox"/> 2020 <input type="checkbox"/> 2021

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation**Short Form Annual Return/Report of Small Employee
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☐ 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

2b Employer Identification Number
(EIN) 45-5026526**2c** Sponsor's telephone number
(516) 633-1439**2d** Business code (see instructions)

11 Hemlock Lane

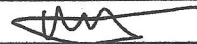
Roslyn Heights

NY 11577

621111

3a Plan administrator's name and address ☒ Same as Plan Sponsor.**3b** Administrator's EIN**3c** Administrator's telephone number**4** If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.**a** Sponsor's name**c** Plan Name**4b** EIN**4d** PN**5a** Total number of participants at the beginning of the plan year**5a** 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.**

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SIGN HERE	<input checked="" type="checkbox"/> 	3/14/23	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 (2022)
v.220413

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation**Short Form Annual Return/Report of Small Employee
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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

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 ☒ 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Usman Saleem
	Signature of plan administrator		Date
SIGN HERE			
	Signature of employer/plan sponsor		Date

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

Form 5500-SF (2022)
v.220413

- 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	1,864,444	1,744,374
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	1,864,444	1,744,374

8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	252,270	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	-360,562	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		-108,292
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	11,778	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		11,778
i Net income (loss) (subtract line 8h from line 8c)	8i		-120,070
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		174,438
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.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/>	Yes.	
<input type="checkbox"/>	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.	
<input type="checkbox"/>	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.	
<input type="checkbox"/>	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.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Part VII Plan Terminations and Transfers of Assets

13a	Has a resolution to terminate the plan been adopted in any plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)	13c(2)	13c(3)
Name of plan(s):	EIN(s)	PN(s)

**SCHEDULE SB
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment 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

2022**This Form is Open to Public
Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

▶ **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>2022</u>			
2 Assets:			
a Market value	2a	1,492,104	
b Actuarial value	2b	1,492,104	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	0	0	0
b For terminated vested participants	0	0	0
c For active participants	3	1,464,251	1,469,524
d Total	3	1,464,251	1,469,524
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		5.84 %
6 Target normal cost			
a Present value of current plan year accruals	6a		260,833
b Expected plan-related expenses	6b		11,778
c Total (line 6a + line 6b)	6c		272,611

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

04/26/2023

Date

Charles Stipelman, FSPA

Type or print name of actuary

23-02286

Most recent enrollment number

National Professional Planning Gro

Firm name

(732) 758-1577

Telephone number (including area code)

494 Sycamore Avenue - Suite 100

Shrewsbury

NJ 07702

Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐**For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.****Schedule SB (Form 5500) 2022
v. 220413**

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)		275303
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>5.41</u> %		14894
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		290197
d Portion of (c) to be added to prefunding balance		290197
12 Other reductions in balances due to elections or deemed elections	0	290197
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	101.53%
15 Adjusted funding target attainment percentage	15	101.53%
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	%
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
02/23/2023	250,000				
02/26/2023	2,270				
Totals ►			18(b)	252,270	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	250,031

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

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

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

21 Discount rate:				
a Segment rates:	1st segment: 4.75 %	2nd segment: 5.18 %	3rd segment: 5.92 %	<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)	<input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> 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.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26 Demographic and benefit information	
a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment...	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6c)	31a	272,611	
b Excess assets, if applicable, but not greater than line 31a	31b	22,580	
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	250,031	
	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	250,031	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	250,031	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	0	
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 the American Rescue Plan Act of 2021 (See Instructions)

41 If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies. <input type="checkbox"/> 2019 <input type="checkbox"/> 2020 <input type="checkbox"/> 2021

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2022)

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

Schedule SB, Lines 7 - 13 – Explanation of Discrepancy in Prior Year Funding Standard
Carryover or Prefunding Balances

For end of year valuations, beginning year entry represents interest at current year effective rate on beginning of year balances for purposes of determining Part III funding percentages and offsets to assets in determining minimum required contributions.

ATTACHMENTS – FORM 5500, SCHEDULE SB (PYE 12/31/2022)

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 12/31/2022)

Plan: Innovative Medical Healthcare, PC Defined Benefit Plan

EID#: 45-5026526 / 001

PART V : STATEMENT OF ACTUARIAL ASSUMPTIONS AND METHODS

Interest :	1.95%, 3.50%, 3.85% (IRC 404) 4.75%, 5.18%, 5.92% (IRC 430, AFTAP) 5.84% (effective rate)
Mortality :	Prescribed, combined – 2022
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 12/31/2022)

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 12/31/2022)

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+							