

**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

**2022**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

- 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

<b>1a</b> Name of plan AGGARWAL ALLERGY CLINIC, P.C. CASH BALANCE PLAN		<b>1b</b> Three-digit plan number (PN) ▶	002
		<b>1c</b> Effective date of plan	01/01/2012
<b>2a</b> 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) AGGARWAL ALLERGY CLINIC, P.C.  600 N.W. MURRAY ROAD, SUITE 306 LEES SUMMIT, MO 64081		<b>2b</b> Employer Identification Number (EIN)	74-2954940
		<b>2c</b> Sponsor's telephone number	816-525-8400
		<b>2d</b> Business code (see instructions)	621399
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		<b>3b</b> Administrator's EIN	
		<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. <b>a</b> Sponsor's name <b>c</b> Plan Name		<b>4b</b> EIN	
		<b>4d</b> PN	
<b>5a</b> Total number of participants at the beginning of the plan year.....		<b>5a</b>	10
<b>b</b> Total number of participants at the end of the plan year .....		<b>5b</b>	1
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....		<b>5c</b>	
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....		<b>5d(1)</b>	9
<b>d(2)</b> Total number of active participants at the end of the plan year.....		<b>5d(2)</b>	0
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		<b>5e</b>	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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/23/2023	RYAN OKEEFE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/23/2023	RYAN OKEEFE
	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.)

<b>Part III Financial Information</b>			
<b>7</b>		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b>	Total plan assets.....	5955903	2679
<b>b</b>	Total plan liabilities.....	0	0
<b>c</b>	Net plan assets (subtract line 7b from line 7a).....	5955903	2679
<b>8</b>		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b>	Contributions received or receivable from:		
	(1) Employers.....	750000	
	(2) Participants.....	0	
	(3) Others (including rollovers).....	0	
<b>b</b>	Other income (loss).....	-437141	
<b>c</b>	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....		312859
<b>d</b>	Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	6248739	
<b>e</b>	Certain deemed and/or corrective distributions (see instructions).....	0	
<b>f</b>	Administrative service providers (salaries, fees, commissions).....	0	
<b>g</b>	Other expenses.....	0	
<b>h</b>	Total expenses (add lines 8d, 8e, 8f, and 8g).....		6248739
<b>i</b>	Net income (loss) (subtract line 8h from line 8c).....		-5935880
<b>j</b>	Transfers to (from) the plan (see instructions).....	-17344	

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

<b>Part V Compliance Questions</b>				
<b>10</b>		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<b>a</b>	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).....		X	
<b>b</b>	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.).....		X	
<b>c</b>	Was the plan covered by a fidelity bond?.....	X		260000
<b>d</b>	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?.....		X	
<b>e</b>	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.).....		X	
<b>f</b>	Has the plan failed to provide any benefit when due under the plan?.....		X	
<b>g</b>	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.).....		X	
<b>h</b>	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....			
<b>i</b>	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.....			

**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? .....  Yes  No  
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

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

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

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

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

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

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

**Part VII Plan Terminations and Transfers of Assets**

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

If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a** 0

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

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

<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  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).  <b>▶ File as an attachment to Form 5500 or 5500-SF.</b>	<small>OMB No. 1210-0110</small>  <b>2022</b>  <b>This Form is Open to Public Inspection</b>
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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.

<b>A</b> Name of plan <u>AGGARWAL ALLERGY CLINIC, P.C. CASH BALANCE PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>AGGARWAL ALLERGY CLINIC, P.C.</u>	<b>D</b> Employer Identification Number (EIN) <u>74-2954940</u>	

**E** Type of plan:  Single  Multiple-A  Multiple-B **F** Prior year plan size:  100 or fewer  101-500  More than 500

<b>Part I Basic Information</b>			
<b>1</b> Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2022</u>			
<b>2</b> Assets:			
<b>a</b> Market value.....	<b>2a</b>	<u>5955903</u>	
<b>b</b> Actuarial value.....	<b>2b</b>	<u>5955903</u>	
<b>3</b> Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
<b>a</b> For retired participants and beneficiaries receiving payment .....	<u>0</u>	<u>0</u>	<u>0</u>
<b>b</b> For terminated vested participants.....	<u>1</u>	<u>1678</u>	<u>1678</u>
<b>c</b> For active participants.....	<u>9</u>	<u>4943056</u>	<u>4944009</u>
<b>d</b> Total .....	<u>10</u>	<u>4944734</u>	<u>4945687</u>
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
<b>a</b> Funding target disregarding prescribed at-risk assumptions.....	<b>4a</b>		
<b>b</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.....	<b>4b</b>		
<b>5</b> Effective interest rate.....	<b>5</b>	<u>4.80 %</u>	
<b>6</b> Target normal cost.....			
<b>a</b> Present value of current plan year accruals.....	<b>6a</b>	<u>270644</u>	
<b>b</b> Expected plan-related expenses .....	<b>6b</b>	<u>0</u>	
<b>c</b> Total (line 6a + line 6b) .....	<b>6c</b>	<u>270644</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.

<b>SIGN HERE</b>		
	Signature of actuary	<u>05/25/2023</u> Date
	<u>R. ANDREW HARTNETT, JR.</u> Type or print name of actuary	<u>23-08516</u> Most recent enrollment number
	<u>THE PENSION SERVICE, INC.</u> Firm name	<u>203-234-2229</u> Telephone number (including area code)
	<u>127 WASHINGTON AVENUE FIRST FLOOR, WEST WING NORTH HAVEN, CT 06473</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 V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 4.75 %	2nd segment: 5.18 %	3rd segment: 5.92 %	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code).....				<b>21b</b> 2
<b>22</b> Weighted average retirement age .....				<b>22</b> 67
<b>23</b> Mortality table(s) (see instructions)	<input checked="" type="checkbox"/> Prescribed - combined	<input type="checkbox"/> Prescribed - separate	<input type="checkbox"/> Substitute	

**Part VI Miscellaneous Items**

<b>24</b> 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
<b>25</b> 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
<b>26</b> Demographic and benefit information		
<b>a</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>b</b> Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ...	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment .....	<b>27</b>	

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

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

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6c).....	<b>31a</b>	270644	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	270644	
<b>32</b> Amortization installments:	Outstanding Balance	Installment	
<b>a</b> Net shortfall amortization installment .....	0	0	
<b>b</b> Waiver amortization installment.....	0	0	
<b>33</b> 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 .....	<b>33</b>		
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)....	<b>34</b>	0	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement.....	0	0	0
<b>36</b> Additional cash requirement (line 34 minus line 35).....	<b>36</b>	0	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	<b>37</b>	719818	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36)	<b>38a</b>	719818	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37).....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years.....	<b>40</b>	0	

**Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)**

<b>41</b> 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
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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.

<b>A</b> Name of plan <u>Aggarwal Allergy Clinic, P.C. Cash Balance Plan</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>Aggarwal Allergy Clinic, P.C.</u>	<b>D</b> Employer Identification Number (EIN) <u>74-2954940</u>	

**E** Type of plan:  Single  Multiple-A  Multiple-B  Multiple-C  Multiple-D  Multiple-E  Multiple-F  Other

**F** Prior year plan size:  100 or fewer  101-500  More than 500

**Part I Basic Information**

**1** Enter the valuation date: Month 01 Day 01 Year 2022

<b>2</b> Assets:		
<b>a</b> Market value .....	<b>2a</b>	5,955,903
<b>b</b> Actuarial value .....	<b>2b</b>	5,955,903

3 Funding target/participant count breakdown:	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
<b>a</b> For retired participants and beneficiaries receiving payment ....	0	0	0
<b>b</b> For terminated vested participants .....	1	1,678	1,678
<b>c</b> For active participants .....	9	4,943,056	4,944,009
<b>d</b> Total .....	10	4,944,734	4,945,687

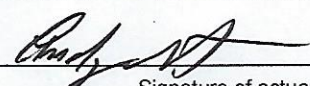
**4** If the plan is in at-risk status, check the box and complete lines (a) and (b)

<b>a</b> Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>	
<b>b</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 .....	<b>4b</b>	

**5** Effective interest rate ..... **5** 4.80 %

<b>6</b> Target normal cost .....		
<b>a</b> Present value of current plan year accruals .....	<b>6a</b>	270,644
<b>b</b> Expected plan-related expenses .....	<b>6b</b>	0
<b>c</b> Total (line 6a + line 6b) .....	<b>6c</b>	270,644

**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.

<p><b>SIGN HERE</b></p> <p style="text-align: center;"> Signature of actuary</p> <p><u>R. Andrew Hartnett, Jr.</u> Type or print name of actuary</p> <p><u>The Pension Service, Inc.</u> Firm name</p> <p><u>127 Washington Avenue</u> <u>First Floor, West Wing</u> <u>US North Haven CT 06473</u> Address of the firm</p>	<p style="text-align: center;"><u>05/25/2023</u> Date</p> <p style="text-align: center;"><u>23-08516</u> Most recent enrollment number</p> <p style="text-align: center;"><u>(203) 234-2229</u> Telephone number (including area code)</p>
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

<b>Part II Beginning of Year Carryover and Prefunding Balances</b>		(a) Carryover balance	(b) Prefunding balance
<b>7</b>	Balance at beginning of prior year after applicable adjustments (line 13 from prior year) .....	0	0
<b>8</b>	Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....	0	0
<b>9</b>	Amount remaining (line 7 minus line 8) .....	0	0
<b>10</b>	Interest on line 9 using prior year's actual return of <u>13.62</u> % .....	0	0
<b>11</b>	Prior year's excess contributions to be added to prefunding balance:		
<b>a</b>	Present value of excess contributions (line 38a from prior year) .....		0
<b>b(1)</b>	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>5.53</u> % ...		0
<b>b(2)</b>	Interest on line 38b from prior year Schedule SB, using prior year's actual return .....		0
<b>c</b>	Total available at beginning of current plan year to add to prefunding balance		0
<b>d</b>	Portion of (c) to be added to prefunding balance .....		0
<b>12</b>	Other reductions in balances due to elections or deemed elections .....	0	0
<b>13</b>	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12) ....	0	0

<b>Part III Funding Percentages</b>			
<b>14</b>	Funding target attainment percentage .....	<b>14</b>	120.42 %
<b>15</b>	Adjusted funding target attainment percentage .....	<b>15</b>	120.42 %
<b>16</b>	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement .....	<b>16</b>	124.74 %
<b>17</b>	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage .....	<b>17</b>	%

<b>Part IV Contributions and Liquidity Shortfalls</b>							
<b>18</b> Contributions made to the plan for the plan year by employer(s) and employees:							
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
11/17/2022	750,000	0					
			<b>Totals ▶</b>	<b>18(b)</b>	750,000	<b>18(c)</b>	0

<b>19</b> Discounted employer contributions -- see instructions for small plan with a valuation date after the beginning of the year:			
<b>a</b>	Contributions allocated toward unpaid minimum required contributions from prior years .....	<b>19a</b>	0
<b>b</b>	Contributions made to avoid restrictions adjusted to valuation date .....	<b>19b</b>	0
<b>c</b>	Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....	<b>19c</b>	719,818
<b>20</b> Quarterly contributions and liquidity shortfalls:			
<b>a</b>	Did the plan have a "funding shortfall" for the prior year? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>b</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	
<b>c</b>	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
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**b** Applicable month (enter code) ..... **21b** 2

**22** Weighted average retirement age ..... **22** 67

**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** Demographic and benefit information

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

**b** Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment .....  Yes  No

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

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

**28** Unpaid minimum required contributions for all prior years ..... **28** 0

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

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

**Part VIII Minimum Required Contribution For Current Year**

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

**a** Target normal cost (line 6c) ..... **31a** 270,644

**b** Excess assets, if applicable, but not greater than line 31a ..... **31b** 270,644

**32** Amortization installments:

	Outstanding Balance	Installment
<b>a</b> Net shortfall amortization installment .....	0	0
<b>b</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
<b>35</b> Balances elected for use to offset funding requirement .....	0	0	0
<b>36</b> Additional cash requirement (line 34 minus line 35) .....			0
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....			719,818

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

**a** Total (excess, if any, of line 37 over line 36) ..... **38a** 719,818

**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.  2019  2020  2021

**E-SIGNATURE AUTHORIZATION**  
**for**  
**Aggarwal Allergy Clinic, P.C. Cash Balance Plan**  
**74-2954940/002**  
**For Plan Year 01/01/2022 through 12/31/2022**

I/We, the undersigned, understand that a 5500 Series filing for the plan listed above must be prepared, electronically signed and electronically transmitted to the EBSA Electronic Filing Acceptance System (EFAST).

I/We authorize Demars Consulting Services, Inc. to electronically sign the 5500 Series filing on my/our behalf and to transmit that signed form to EFAST on or before the filing due date.

I/We understand that by granting this authority:

- A manually signed and dated Form 5500-SF that has been provided must be returned to Demars Consulting Services, Inc. before they can begin the electronic filing process. I/We will retain a copy of this manually signed form and any schedules and attachments in the plan records.
  - Demars Consulting Services, Inc. will not be responsible for any late filing penalty assessed under ERISA should I/we not return the manually signed and dated Form 5500-SF prior to the filing due date.
- An electronic copy of the manually signed and dated Form 5500-SF showing my/our signatures will be included in the electronic filing and will be posted by the EBSA to the Internet for public disclosure.
- Demars Consulting Services, Inc. will maintain a copy of this written authorization in its records.
- Demars Consulting Services, Inc. will notify all signers about any inquiries and correspondence it receives about this filing from EFAST, EBSA, IRS or PBGC.
- Demars Consulting Services, Inc. shall not be deemed to be a plan fiduciary with respect to this plan solely on account of providing the electronic signature and filing of the 5500-SF for the plan year listed above.

\_\_\_\_\_  
Plan Administrator

\_\_\_\_\_  
Plan Sponsor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**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 section 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  
1210-0039

**2022**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

**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)

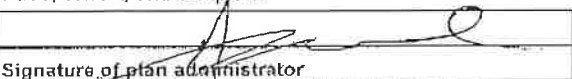
**D** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here . . . . .

**Part II Basic Plan Information --- enter all requested information**

<b>1a</b> Name of plan Aggarwal Allergy Clinic, P.C. Cash Balance Plan	<b>1b</b> Three-digit plan number (PN) ▶ 002
	<b>1c</b> Effective date of plan 01/01/2012
<b>2a</b> 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) Aggarwal Allergy Clinic, P.C.  600 N.W. Murray Road, Suite 306  Us Lees Summit MO 64081	<b>2b</b> Employer Identification Number (EIN) 74-2954940
	<b>2c</b> Sponsor's telephone number (816) 525-8400
	<b>2d</b> Business code (see instructions) 621399
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
<b>5a</b> Total number of participants at the beginning of the plan year	<b>5a</b> 10
<b>b</b> Total number of participants at the end of the plan year	<b>5b</b> 1
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>5c</b>
<b>d(1)</b> Total number of active participants at the beginning of the plan year	<b>5d(1)</b> 9
<b>d(2)</b> Total number of active participants at the end of the plan year	<b>5d(2)</b> 0
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>5e</b> 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.

<b>SIGN HERE</b>		6/21/23	Jag Aggarwal
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			Jag Aggarwal
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

**Aggarwal Allergy Clinic, P.C. Cash Balance Plan**

**EIN: 74-2954940, PN: 002**

**Schedule SB, line 22, – Description of Weighted Average Retirement Age:**

Normal Retirement Age – The later of 62 or 3 Years of Participation.

All participants are assumed to retire at the Normal Retirement Age or attained age if later.

The weighted average retirement age is 67.



## ACTUARIAL METHODS AND ASSUMPTIONS

<b><u>Actuarial Cost Method:</u></b>	Pension Protection Act (“PPA”) prescribed actuarial cost method.
<b><u>Asset Valuation Method:</u></b>	Market value.
<b><u>Target Liability</u></b>	
<b><u>Interest Rates:</u></b>	PPA prescribed segment rates as of the valuation date adjusted by MAP-21 and adjusted by ARPA.
<b><u>Effective Interest Rate:</u></b>	Equivalent single interest rate used to value target liability: 4.80%
<b><u>Salary Increases:</u></b>	None assumed.
<b><u>Mortality Assumption:</u></b>	2022 static table in accordance with IRS Regulation 1.430(h)(3)-1.
<b><u>Retirement Rates:</u></b>	Normal Retirement Age or attained age if later.
<b><u>Withdrawal Rates:</u></b>	None assumed.
<b><u>Disability Rates:</u></b>	None assumed.
<b><u>Form of Payment:</u></b>	Life annuity.
<b><u>Expense Load:</u></b>	Prior year expenses, rounded to nearest \$1,000; included in target normal cost.

Aggarwal Allergy Clinic, P.C. Cash Balance Plan  
EIN: 74-2954940  
Plan # 002

## SUMMARY OF PLAN PROVISIONS

<b><u>Effective Date:</u></b>	January 1, 2012
<b><u>Eligible Employees:</u></b>	Employees who are age 21 with one (1) year of service.
<b><u>Years of Service:</u></b>	Each calendar year during which an employee is paid for at least 1000 hours.
<b><u>Normal Retirement Date:</u></b>	The Later of Age 62 or the 3rd Anniversary of Participation.
<b><u>Accrued Benefit:</u></b>	Equals the Hypothetical account, which is the sum of Hypothetical Allocations and Interest Credits for each Year of Service.
<b><u>Groups:</u></b>	Group A: Direct and Indirect Owners of the Employer Group B: All other eligible employees of the Employer
<b><u>Hypothetical Allocation:</u></b>	For each Plan Year equal to: Group A: 96.00% of determination period compensation Group B: 3.50% of determination period compensation
<b><u>Interest Credits:</u></b>	Increase of the Hypothetical Account as of beginning of Plan Year by 4.50%.
<b><u>Normal Form of Benefit:</u></b>	Actuarially reduced monthly Joint & 50% Survivor Annuity if married; Single Life Annuity if unmarried.
<b><u>Optional Forms:</u></b>	Lump sum value of the Hypothetical Account; Joint & 50%, 66 2/3%, 75% and 100% and Survivor Annuities if married.
<b><u>Pre-Retirement Death Benefit:</u></b>	Benefit accrued to date of death.
<b><u>Vesting:</u></b>	100% after three years of service.

**NOTE: The plan was terminated effective June 30, 2022.**