

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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- A** This return/report is for: a single-employer plan a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans 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 the plan is a collectively-bargained plan, check here ▶
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>GASTROENTEROLOGY ASSOCIATES, P.C. CASH BALANCE PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>006</u></p>	
	<p>1c Effective date of plan <u>03/01/2020</u></p>	
<p>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>GASTROENTEROLOGY ASSOCIATES, P.C.</u> <u>8640 SUDLEY ROAD, SUITE 201</u> <u>MANASSAS, VA 20110-4416</u></p>	<p>2b Employer Identification Number (EIN) <u>54-1604636</u></p>	
	<p>2c Sponsor's telephone number <u>571-248-0653</u></p>	
	<p>2d Business code (see instructions) <u>621111</u></p>	
<p>3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.</p>	<p>3b Administrator's EIN</p>	
	<p>3c Administrator's telephone number</p>	
<p>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</p>	<p>4b EIN</p>	
	<p>4d PN</p>	
<p>5a Total number of participants at the beginning of the plan year</p>	5a	<u>28</u>
<p>b Total number of participants at the end of the plan year.....</p>	5b	<u>0</u>
<p>c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p>	5c(1)	
<p>c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p>	5c(2)	
<p>d(1) Total number of active participants at the beginning of the plan year.....</p>	5d(1)	<u>28</u>
<p>d(2) Total number of active participants at the end of the plan year.....</p>	5d(2)	<u>0</u>
<p>e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</p>	5e	<u>0</u>

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

SIGN HERE	Filed with authorized/valid electronic signature.	09/06/2024	EDWARD KIM, MD
	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 516122. (See instructions.)

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1517408	0
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1517408	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	0	
(2) Participants.....	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss).....	8b	34723	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	8c		34723
d Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	8d	1060742	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	11121	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		1071863
i Net income (loss) (subtract line 8h from line 8c).....	8i		-1037140
j Transfers to (from) the plan (see instructions)	8j	-480268	

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 1C 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? Continue to answer "Yes" for any prior year failures until fully corrected. (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		500000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		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		X	
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** 2457

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

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

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

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

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)
AON POOLED EMPLOYER PLAN	22-2232264	001

Part VIII IRS Compliance Questions

14a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

14b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- Design-based safe harbor method
- "Prior year" ADP test
- "Current year" ADP test
- N/A

15 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 03/30/2018 (MM/DD/YYYY) and the Opinion Letter serial number J501819A.

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> 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

▶ **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>GASTROENTEROLOGY ASSOCIATES, P.C. CASH BALANCE PLAN</u>	B Three-digit plan number (PN) ▶	<u>006</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>GASTROENTEROLOGY ASSOCIATES, P.C.</u>	D Employer Identification Number (EIN) <u>54-1604636</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>01</u> Day <u>01</u> Year <u>2023</u>		
2	Assets:		
	a Market value	2a	<u>1511884</u>
	b Actuarial value	2b	<u>1511884</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>4</u>	<u>22266</u>
	c For active participants	<u>24</u>	<u>1507957</u>
	d Total	<u>28</u>	<u>1530223</u>
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b	
5	Effective interest rate	5	<u>5.07 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>0</u>
	b Expected plan-related expenses	6b	<u>2258</u>
	c Target normal cost	6c	<u>2258</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>03/29/2024</u> Date
	<u>LORRAINE DORSA</u> Type or print name of actuary	<u>23-04253</u> Most recent enrollment number
	<u>AEGIS PENSION SERVICES, INC.</u> Firm name	<u>904-686-1835</u> Telephone number (including area code)
	<u>150 PROFESSIONAL DRIVE SUITE 200 US PONTE VEDRA BEACH, FL 32082</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 <u>-5.49</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		255029
	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>5.29</u> %		13491
	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		268520
	d Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages			
14	Funding target attainment percentage	14	98.80 %
15	Adjusted funding target attainment percentage	15	98.80 %
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	86.40 %
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	
Totals ▶			18(b)	0	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	0

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: 5.00 %	3rd segment: 5.74 %	<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 type="checkbox"/> Yes	<input checked="" 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	2258	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	18339	199	
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	2457	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0
36 Additional cash requirement (line 34 minus line 35).....	36	2457	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	0	
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	2457	
40 Unpaid minimum required contributions for all years	40	2457	

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

Schedule SB, Part V Statement of Actuarial Assumptions/Methods

Gastroenterology Associates, PC Cash Balance Plan
54-1604636 / 006

For the plan year 01/01/2023 through 12/31/2023

Valuation Date: 01/01/2023

Funding Method: As prescribed in IRC Section 430
Age - Eligibility age at last birthday and other ages at nearest birthday
New participants are not included in current year's valuation

Retrospective Compensation - Current compensation

Form of Payment - Assumed form of payment for funding is 1% Life Annuity and 99% lump sum which is the Hypothetical Account Balance. Funding Target for lump sum is the current Hypothetical Account Balance projected to the assumed retirement date using the Interest Credit Rate discounted using appropriate segment rate. Lump sum on plan actuarial equivalence rates will not exceed 415 maximum allowable distribution, which is the lesser amount computed using a) 5.5% interest and the Applicable Mortality Table or b) plan actuarial equivalence interest and mortality

Interest Rates -	Segment rates for the Valuation Date as permitted under IRC 430(h)(2)(C)	Segment rates as of September 30, 2022 As permitted under IRC 430(h)(2)(C)(iv)(II) - ARP																								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Segment #</th> <th style="text-align: left;">Year</th> <th style="text-align: left;">Rate %</th> </tr> </thead> <tbody> <tr> <td>Segment 1</td> <td>0 - 5</td> <td>2.13</td> </tr> <tr> <td>Segment 2</td> <td>6 - 20</td> <td>3.62</td> </tr> <tr> <td>Segment 3</td> <td>> 20</td> <td>3.93</td> </tr> </tbody> </table>	Segment #	Year	Rate %	Segment 1	0 - 5	2.13	Segment 2	6 - 20	3.62	Segment 3	> 20	3.93	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Segment #</th> <th style="text-align: left;">Year</th> <th style="text-align: left;">Rate %</th> </tr> </thead> <tbody> <tr> <td>Segment 1</td> <td>0 - 5</td> <td>4.75</td> </tr> <tr> <td>Segment 2</td> <td>6 - 20</td> <td>5.00</td> </tr> <tr> <td>Segment 3</td> <td>> 20</td> <td>5.74</td> </tr> </tbody> </table>	Segment #	Year	Rate %	Segment 1	0 - 5	4.75	Segment 2	6 - 20	5.00	Segment 3	> 20	5.74
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Segment 3	> 20	5.74																								

Pre-Retirement - Mortality Table - None
 Early Retirement Table - None
 Turnover Table - None
 Disability Table - None
 Salary Scale - None
 Interest Credit Rate - Current Yr - 5% Projected Yrs - 5%
 Expense Load - \$2,258
 Ancillary Ben Load - None

Post-Retirement - Mortality Table - 23C - 2023 Combined

Cost of Living - None

Asset Valuation Method: Fair market value of assets adjusted for contributions under IRC 430(g)(4)



Authorization for Retirement Benefit Solutions to Electronically Sign and File Form 5500
Please sign and return this Form to Retirement Benefit Solutions

Plan Name: Gastroenterology Associates, PC Cash Balance Plan final filing
Plan Year Ending: 2023

I hereby authorize Retirement Benefit Solutions to electronically sign and file the Form 5500 forms on my behalf.

I further understand the following:

- I must sign and date a paper copy of the completed Form 5500;
- Retirement Benefit Solutions must receive the signed paper copy prior to submitting the Form 5500 filing;
- An image of my signature will be included with the rest of the return/report posted by the Department of Labor on the internet for public disclosure; and
- This authorization applies only to the filing for the plan name and plan year specified above.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including all applicable schedules, 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.

Plan Administrator Signature:  Date: 9/9/2024

Printed Name of Plan Administrator: Edward C Kim, MD

Return of Excise Taxes Related to Employee Benefit Plans

(under sections 4965, 4971, 4972, 4973(a)(3), 4975, 4976, 4977, 4978, 4979, 4979A, 4980, and 4980F of the Internal Revenue Code)

OMB No. 1545-0575

Go to www.irs.gov/Form5330 for instructions and the latest information.

Filer tax year beginning _____, and ending _____,	
A Name of filer (see instructions) <u>Gastroenterology Associates, PC</u> Number, street, and room or suite no. (If a P.O. box or foreign address, see instructions.) <u>8640 Sudley Road, Suite 201</u> City or town, state or province, country, and ZIP or foreign postal code <u>Manassas, VA 20110-4416</u>	B Filer's identifying number (Enter either the EIN or SSN, but not both. See instructions.) Employer identification number (EIN) <u>54-1604636</u> Social security number (SSN)
C Name of plan <u>Gastroenterology Associates, PC Cash Balance Plan</u>	E Plan sponsor's EIN <u>54-1604636</u>
D Name and address of plan sponsor <u>8640 Sudley Road, Suite 201 Manassas, VA 20110-4416</u>	F Plan year ending (MM/DD/YYYY) <u>12/31/2023</u>
H If this is an amended return, check here <input type="checkbox"/>	G Plan number <u>006</u>

Part I Taxes. You can only complete one section of Part I for each Form 5330 filed. See instructions.

Section A. Taxes that are reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)	FOR IRS USE ONLY		
1 Section 4972 tax on nondeductible contributions to qualified plans (from Schedule A, line 12)	161	1	
2 Section 4973(a)(3) tax on excess contributions to section 403(b)(7)(A) custodial accounts (from Schedule B, line 12)	164	2	
3a Section 4975(a) tax on prohibited transactions (from Schedule C, line 3)	159	3a	
b Section 4975(b) tax on failure to correct prohibited transactions	224	3b	
4 Section 4976 tax on disqualified benefits for funded welfare plans	200	4	
5a Section 4978 tax on ESOP dispositions	209	5a	
b The tax on line 5a is a result of the application of: <input type="checkbox"/> Sec. 664(g) <input type="checkbox"/> Sec. 1042		5b	
6 Section 4979A tax on certain prohibited allocations of qualified ESOP securities or ownership of synthetic equity	203	6	
7 Total Section A taxes. Add lines 1 through 6. Enter here and on Part II, line 17		7	

Section B. Taxes that are reported by the 15th day of the 10th month after the last day of the plan year		
8a Section 4971(a) tax on failure to meet minimum funding standards (from Schedule D, line 2)	163	8a
b Section 4971(b) tax for failure to correct minimum funding standards	225	8b
9a Section 4971(f)(1) tax on failure to pay liquidity shortfall (from Schedule E, line 4)	226	9a
b Section 4971(f)(2) tax for failure to correct liquidity shortfall	227	9b
10a Section 4971(g)(2) tax on failure to comply with a funding improvement or rehabilitation plan (see instructions)	450	10a
b Section 4971(g)(3) tax on failure to meet requirements for plans in endangered or critical status (from Schedule F, line 1c)	451	10b
c Section 4971(g)(4) tax on failure to adopt rehabilitation plan (from Schedule F, line 2d)	452	10c
d Section 4971(h) tax on failure of a CSEC plan sponsor to adopt funding restoration plan (from Schedule L, line 2)	453	10d

Section B1. Tax that is reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees		
11 Section 4977 tax on excess fringe benefits (from Schedule G, line 4)	201	11
12 Total Section B taxes. Add lines 8a through 10d or 11. Enter here and on Part II, line 17		12

Section C. Tax that is reported by the last day of the 15th month after the end of the plan year		
13 Section 4979 tax on excess contributions to certain plans (from Schedule H, line 2). Enter here and on Part II, line 17	205	13

Name of filer: _____ Filer's identifying number: _____

Section D. Tax that is reported by the last day of the month following the month in which the reversion occurred

14	Section 4980 tax on reversion of qualified plan assets to an employer (from Schedule I, line 3). Enter here and on Part II, line 17	204	14
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Section E. Tax that is reported by the last day of the month following the month in which the failure occurred

15	Section 4980F tax on failure to provide notice of significant reduction in future accruals (from Schedule J, line 5). Enter here and on Part II, line 17	228	15
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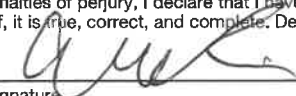
Section F. Taxes reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

16	Section 4965 tax on prohibited tax shelter transactions for entity managers (from Schedule K, line 2). Enter here and on Part II, line 17	237	16
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Part II Tax Due

17	Enter the amount from Part I, line 7, 12, 13, 14, 15, or 16 (whichever is applicable)	17	0
18	Enter the amount of tax paid with Form 5558 or any other tax paid prior to filing this return	18	245.70
19	Tax due. Subtract line 18 from line 17. If the result is greater than zero, enter here	19	245.70

Sign Here Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature:  Telephone number: 703-368-6819 Date: 9/9/2024

Paid Preparer Use Only

Print/Type preparer's name Patricia A Curtis	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
Firm's name Retirement Benefit Solutions	Firm's EIN 54-1953648		Phone no. 703-750-6750	
Firm's address 205 Van Buren Street, Suite 120 Herndon, VA 20170				

Name of filer:

Filer's identifying number:

Schedule A. Tax on Nondeductible Employer Contributions to Qualified Employer Plans (Section 4972) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total contributions for your tax year to your qualified employer plan (under section 401(a), 403(a), 408(k), or 408(p))	1	
2	Amount allowable as a deduction under section 404	2	
3	Subtract line 2 from line 1	3	
4	Enter amount of any prior year nondeductible contributions made for years beginning after 12/31/86	4	
5	Amount of any prior year nondeductible contributions for years beginning after 12/31/86 returned to you in this tax year for any prior tax year	5	
6	Subtract line 5 from line 4	6	
7	Amount of line 6 carried forward and deductible in this tax year	7	
8	Subtract line 7 from line 6	8	
9	Tentative taxable excess contributions. Add lines 3 and 8	9	
10	Nondeductible section 4972(c)(6) or (7) contributions exempt from excise tax	10	
11	Taxable excess contributions. Subtract line 10 from line 9	11	
12	Multiply line 11 by 10%. Enter here and on Part I, line 1	12	

Schedule B. Tax on Excess Contributions to Section 403(b)(7)(A) Custodial Accounts (Section 4973(a)(3)) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total amount contributed for current year less rollovers. See instructions	1	
2	Amount excludable from gross income under section 403(b). See instructions	2	
3	Current year excess contributions. Subtract line 2 from line 1. If zero or less, enter -0-	3	
4	Prior year excess contributions not previously eliminated. If zero, go to line 8	4	
5	Contribution credit. If line 2 is more than line 1, enter the excess; otherwise, enter -0-	5	
6	Total of all prior years' distributions out of the account included in your gross income under section 72(e) and not previously used to reduce excess contributions	6	
7	Adjusted prior years' excess contributions. Subtract the total of lines 5 and 6 from line 4	7	
8	Taxable excess contributions. Add lines 3 and 7	8	
9	Multiply line 8 by 6%	9	
10	Enter the value of your account as of the last day of the year	10	
11	Multiply line 10 by 6%	11	
12	Excess contributions tax. Enter the lesser of line 9 or line 11 here and on Part I, line 2	12	

Name of filer: _____ Filer's identifying number: _____

Schedule F. Tax on Multiemployer Plans in Endangered or Critical Status (Sections 4971(g)(3) and 4971(g)(4)) Reported by the 15th day of the 10th month after the last day of the plan year

Table with 4 main rows and sub-rows (a, b, c, d) for each. Columns include description and numbered boxes (1a-2d) for input.

Schedule G. Tax on Excess Fringe Benefits (Section 4977) Reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees

Table with 4 rows for questions regarding fringe benefits and corresponding numbered boxes (1-4).

Schedule H. Tax on Excess Contributions to Certain Plans (Section 4979) Reported by the last day of the 15th month after the end of the plan year

Table with 2 rows for excess contributions and corresponding numbered boxes (1, 2).

Schedule I. Tax on Reversion of Qualified Plan Assets to an Employer (Section 4980) Reported by the last day of the month following the month in which the reversion occurred

Table with 4 rows for reversion details and corresponding numbered boxes (1, 2a, 3, 4).

Schedule J. Tax on Failure To Provide Notice of Significant Reduction in Future Accruals (Section 4980F) Reported by the last day of the month following the month in which the failure occurred

Table with 6 rows for failure to provide notice and corresponding numbered boxes (1-6).

Schedule K. Tax on Prohibited Tax Shelter Transactions (Section 4965) Reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

Table with 2 rows for prohibited tax shelter transactions and corresponding numbered boxes (1, 2).

Schedule L. Tax on Failure of a CSEC Plan Sponsor To Adopt Funding Restoration Plan (Section 4971(h)) Reported by the 15th day of the 10th month after the last day of the plan year

Table with 2 rows for funding restoration plan failure and corresponding numbered boxes (1, 2).

Form 5500-SF

Department of the Treasury
Internal Revenue Service
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

2023
This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for: a single-employer plan a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEF. Other plans 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 DFCV program special extension (enter description)

D If the plan is a collectively-bargained plan, check here:

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

1a Name of plan: GASTROENTEROLOGY ASSOCIATES, P.C. CASH BALANCE PLAN

1b Three-digit plan number (PN) 006

1c Effective date of plan 03/01/2020

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) GASTROENTEROLOGY ASSOCIATES, P.C.

2b Employer Identification Number (EIN) 54-1604636

2c Sponsor's telephone number 571-248-0653

2d Business code (see instructions) 621111

3a Plan administrator's name and address Same as Plan Sponsor. **3b** Administrator's EIN 621111

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. **4a** Sponsor's name **4b** EIN **4c** Plan Name

5a Total number of participants at the beginning of the plan year 28
5b Total number of participants at the end of the plan year 0
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)
5d(1) Total number of active participants at the beginning of the plan year 28
5d(2) Total number of active participants at the end of the plan year 0
5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 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 Signature of plan administrator: Edward Kim, MD Date: 9/9/2023
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 (QPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Yes No

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 516122. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		
a Total plan assets	(a) Beginning of Year	1,517,408
b Total plan liabilities	(b) End of Year	0

8 Income, Expenses, and Transfers for this Plan Year		
c Net plan assets (subtract line 7b from line 7a)	(a) Amount	1,517,408
b Total plan liabilities	(b) Total	0

a Contributions received or receivable from:		
(1) Employers	8a(1)	0
(2) Participants	8a(2)	
(3) Others (including rollovers)	8a(3)	
b Other income (loss)	8b	34,723
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	34,723
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,060,742
e Certain deemed and/or corrective distributions (see instructions)	8e	
f Administrative service providers (salaries, fees, commissions)	8f	11,121
g Other expenses	8g	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	1,071,863
i Net income (loss) (subtract line 8h from line 8c)	8i	-1,037,140
j Transfers to (from) the plan (see instructions)	8j	-480,268

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 1C 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:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program)	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	
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		X
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		

Amount

500,000

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 1a and b below.) If this is a defined contribution pension plan, leave line 12 blank and complete line 12

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40..... 11a 2,457

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 1 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

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

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

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

13c(1) Name of plan(s): AON Pooled Employer Plan

13c(2) EIN(s): 22-2232264

13c(3) PN(s): 001

Part VIII IRS Compliance Questions

14a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

14b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2). Design-based safe harbor method Prior year ADP test Current year ADP test N/A

15 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter (MM/DD/YYYY) and the Opinion Letter serial number (J501819a) 03/30/2018

**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

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

▶ **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 Gastroenterology Associates, PC Cash Balance Plan		B Three-digit plan number (PN) ▶	006
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Gastroenterology Associates, PC		D Employer Identification Number (EIN) 54-1604636	
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>01</u> Day <u>01</u> Year <u>2023</u>			
2 Assets:			
a Market value	2a	1,511,884	
b Actuarial value	2b	1,511,884	
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	4	22,266	22,266
c For active participants	24	1,507,957	1,507,957
d Total	28	1,530,223	1,530,223
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	5.07 %	
6 Target normal cost			
a Present value of current plan year accruals	6a	0	
b Expected plan-related expenses	6b	2,258	
c Target normal cost	6c	2,258	

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		03/29/2024
	Signature of actuary	Date
	Lorraine Dorsa	23-04253
	Type or print name of actuary	Most recent enrollment number
	Aegis Pension Services, Inc.	(904) 686-1835
	Firm name	Telephone number (including area code)
	150 Professional Drive Suite 200 US Ponte Vedra Beach FL 32082	
	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 <u>-5.49</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		255,029
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>5.29</u> % ...		13,491
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		268,520
d	Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages			
14	Funding target attainment percentage	14	98.80 %
15	Adjusted funding target attainment percentage	15	98.80 %
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	86.40 %
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		
Totals ▶			18(b)	0	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	0
20 Quarterly contributions and liquidity shortfalls:			
a	Did the plan have a "funding shortfall" for the prior year?	<input checked="" type="checkbox"/> Yes <input 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 checked="" 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: 5.00 %	3rd segment: 5.74 %	<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 type="checkbox"/> Yes <input checked="" 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	2,258	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	18,339	199	
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	2,457	
	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	2,457	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	0	
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	2,457	
40 Unpaid minimum required contributions for all years	40	2,457	

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

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

Gastroenterology Associates, PC Cash Balance Plan

54-1604636 / 006

For the plan year 01/01/2023 through 12/31/2023

The age reported is the weighted average of the assumed retirement ages for all active participants as of the valuation date based on their funding target or target normal cost should the funding target of the plan be zero rounded to the nearest whole age. For an active late retiree, the assumed retirement age may be later than the Plan's normal retirement age. Each participant's rate of retirement is assumed to be 100% of his/her assumed retirement age.

Schedule SB, Part V Summary of Plan Provisions

Gastroenterology Associates, PC Cash Balance Plan 54-1604636 / 006

For the plan year 01/01/2023 through 12/31/2023

<u>Employer:</u>	Gastroenterology Associates, PC		
	Type of Entity -	S Corporation	
	EIN: 54-1604636	TIN:	Plan #: 006 Plan Type: Cash Balance
<u>Dates:</u>	Effective -	03/01/2020	Valuation - 01/01/2023
<u>Eligibility:</u>	All employees excluding non-resident aliens, members of an excluded class, union, and excluding members of Cls - "LEASED"		
	Minimum age -	21	Months of service - 12
	Hours Required for -	Eligibility - 1000	Benefit accrual - 1000 Vesting - 1000
	Plan Entry -	First day of 1st or 7th month of plan year on or next following eligibility satisfaction	
<u>Retirement:</u>	Normal -	First of month coincident with or next following attainment of age 62 and completion of 5 years of participation	
	Early -	Not provided	
<u>Average Compensation:</u>	Current compensation		
	Top Heavy Minimum Benefit -	Highest 5 consecutive top heavy years of participation	
<u>Plan Benefits:</u>	Retirement -	Frozen benefit formula	
	Pay Credits -	Classification	Pay Credit Formula
		001	\$100,000
		002	\$75,000
		003	\$50,000
		004	\$25,000
		005	5% of compensation
	Interest Credit Rate -	Current Yr - 5%	Projected Yrs - 5%
	Accrued Benefit -	Frozen accrued benefit as of 11/16/2022	
		Maximum allowable distribution is lump sum equivalent of normal form not to exceed 415 maximum allowable distribution, which is the lesser amount computed using a) 5.5% interest and the Applicable Mortality Table or b) plan actuarial equivalence interest and mortality	
	Early Retirement -	None	
	Death Benefit -	Present Value of Vested Accrued Benefit	
	Disability Benefit -	None	
<u>Top Heavy Minimum:</u>	None		
<u>IRS Limitations:</u>	415 Limits -	Percent: 100	Dollar: \$265,000
	Maximum 401(a)(17) compensation - \$330,000		
<u>PBGC:</u>	Plan is covered by Pension Benefit Guaranty Corporation		
<u>Normal Form:</u>	Life Annuity		
<u>Optional Forms:</u>	Lump Sum Annuity Guaranteed for 0 Years Joint with 50%, 75% or 100% Survivor Benefit		
<u>Vesting Schedule:</u>	100% vested in 3 years. Service is calculated using all years of service		
<u>Present Value of Accrued Benefit:</u>	Based on the Hypothetical Account Balance.		

Schedule SB, Part V Summary of Plan Provisions

Gastroenterology Associates, PC Cash Balance Plan

54-1604636 / 006

For the plan year 01/01/2023 through 12/31/2023

Actuarial Equivalence:

Pre-Retirement - Interest -	5%
Mortality Table -	None
Post-Retirement - Interest -	5%
Mortality Table -	G94 - 1994 Group Annuity Reserving Proj 2002, Scale AA (unisex)

**Schedule SB, line 32 -
Schedule of Amortization Bases**
Gastroenterology Associates, PC Cash Balance Plan
54-1604636 / 006
For the plan year 01/01/2023 through 12/31/2023

Date Base Established	Original Base Amount	Type of Base	Present Value of Remaining Installments	Years Remaining Amortization Period	Amortization Installment
01/01/2022	121,225	Shortfall	116,671	14	11,203
01/01/2023	-98,332	Shortfall	-98,332	15	-9,005
Totals:			\$18,339		\$2,198

Due to the Plan's termination as of 02/02/2023, each amortization installment has been prorated for a resulting charge of \$199.