

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

1a Name of plan <u>DESERT GASTROENTEROLOGY, PLLC CASH BALANCE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>002</u>
	1c Effective date of plan <u>01/01/2019</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>DESERT GASTROENTEROLOGY, PLLC</u> <u>5612 E CALLE DEL PAISANO</u> <u>PHOENIX, AZ 85018</u>	2b Employer Identification Number (EIN) <u>82-3050418</u>
	2c Sponsor's telephone number <u>480-825-0009</u>
	2d Business code (see instructions) <u>621111</u>
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN
	4d PN
5a Total number of participants at the beginning of the plan year	5a <u>2</u>
b Total number of participants at the end of the plan year.....	5b <u>1</u>
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	5c(1)
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c(2)
d(1) Total number of active participants at the beginning of the plan year.....	5d(1) <u>1</u>
d(2) Total number of active participants at the end of the plan year.....	5d(2) <u>1</u>
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	5e <u>0</u>

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/10/2024	ARUN PILLAI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/10/2024	ARUN PILLAI
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	515562	698951
b Total plan liabilities	7b	0	4479
c Net plan assets (subtract line 7b from line 7a)	7c	515562	694472
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	150000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	37745	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		187745
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	4479	
e Certain deemed and/or corrective distributions (see instructions) .	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	4356	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		8835
i Net income (loss) (subtract line 8h from line 8c)	8i		178910
j Transfers to (from) the plan (see instructions)	8j	0	

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 3H
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		51557
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** 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

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

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

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

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

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 J501366A.

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
---	--	--

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>DESERT GASTROENTEROLOGY, PLLC CASH BALANCE PLAN</u>	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>DESERT GASTROENTEROLOGY, PLLC</u>	D Employer Identification Number (EIN) <u>82-3050418</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2023</u>		
2	Assets:		
	a Market value	2a	<u>544472</u>
	b Actuarial value	2b	<u>544472</u>
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment	<u>0</u>	<u>0</u>
	b For terminated vested participants	<u>0</u>	<u>0</u>
	c For active participants	<u>1</u>	<u>606278</u>
	d Total	<u>1</u>	<u>606278</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>5.00 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>126250</u>
	b Expected plan-related expenses	6b	<u>0</u>
	c Target normal cost	6c	<u>126250</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>09/17/2024</u> Date
	<u>STUART BRUNSVOLD</u> Type or print name of actuary	<u>23-07622</u> Most recent enrollment number
	<u>RETIREMENT & INV. SOLUTIONS, CBIZ</u> Firm name	<u>602-277-2371</u> Telephone number (including area code)
	<u>4722 NORTH 24TH STREET, SUITE 300 PHOENIX, AZ 85016</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

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 4
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 type="checkbox"/> Yes	<input checked="" 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	126250	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	61806	5965	
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	132215	
	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	132215	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	139974	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	7759	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

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

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

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

The following actuarial assumptions and methods were used to perform the actuarial valuation as of December 31, 2023.

Interest Rates	Segment Rates for the fourth month prior to the month that contains the valuation date. Minimum Required Contribution: 4.75% - 1 st Segment Rate. 5.00% - 2 nd Segment Rate. 5.74% - 3 rd Segment Rate. Maximum Deductible Contribution: 3.42% - 1 st Segment Rate. 4.33% - 2 nd Segment Rate. 4.43% - 3 rd Segment Rate.
Salary Increases	None Assumed.
Retirement Age	Later of Normal Retirement Date or the end of the Plan Year.
Mortality	Pre-Retirement: None Post-Retirement: Current Applicable Mortality Table under Code Section 417(e)(3) (2023 Applicable Mortality Table)
Withdrawal	None Assumed.
Disability	None Assumed.
Expenses	Plan-related expenses paid during the Plan Year.
Payment Form	100% Elect Lump Sum.
Valuation Date	End of Year.
IRS Limit Increases	None Assumed.
Asset Valuation Method	Market Value.

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Funding Method

Funding method as required by the Pension Protection Act of 2006. Under this method, the plan's funding target is determined as the sum of the actuarial present values (as of valuation date) of the individual accrued benefits taken into account for valuation purposes as of the beginning of the plan year.

The target normal cost is the sum of actuarial present values (on the valuation date) of the benefits deemed to accrue in the plan year.

An individual's accrued benefit for valuation purposes as of any determination date with respect to any assumed separation date(s) is the accrued benefit described under the plan, based on credited service as of the determination date, with plan compensation, benefits, and offset (if any), projected to the separation date.

The benefit deemed to accrue for an individual during a plan year is the excess of the accrued benefit for valuation purposes at the end of the plan year over the accrued benefit for valuation purposes at the beginning of the plan year.

If multiple separation dates are used, the actuarial present values take into account the probability of each separation event.

Changes Since the Prior Valuation

- There were no assumption or method changes since the prior valuation.

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..... ▶

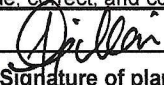
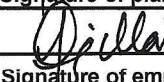
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶

Part II Basic Plan Information—enter all requested information

1a Name of plan Desert Gastroenterology, PLLC Cash Balance Plan	1b Three-digit plan number (PN) ▶ 002
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) Desert Gastroenterology, PLLC 5612 E Calle Del Paisano Phoenix AZ 85018	1c Effective date of plan 01/01/2019
	2b Employer Identification Number (EIN) 82-3050418
	2c Sponsor's telephone number 480-825-0009
	2d Business code (see instructions) 621111
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN
	4d PN
5a Total number of participants at the beginning of the plan year.....	5a 2
b Total number of participants at the end of the plan year.....	5b 1
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item).....	5c(1)
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	5c(2)
d(1) Total number of active participants at the beginning of the plan year.....	5d(1) 1
d(2) Total number of active participants at the end of the plan year.....	5d(2) 1
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	5e 0

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

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

SIGN HERE		10/10/2024	Arun Pillai
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/10/2024	Arun Pillai
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <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.	OMB No. 1210-0110 <hr/> 2023 <hr/> 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 Desert Gastroenterology, PLLC Cash Balance Plan	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Desert Gastroenterology, PLLC	D Employer Identification Number (EIN) 82-3050418	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2023</u>			
2 Assets:			
a Market value.....	2a	544,472	
b Actuarial value	2b	544,472	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	0	0	0
b For terminated vested participants.....	0	0	0
c For active participants.....	1	606,278	606,278
d Total	1	606,278	606,278
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	5.00%	
6 Target normal cost			
a Present value of current plan year accruals.....	6a	126,250	
b Expected plan-related expenses	6b	0	
c Target normal cost.....	6c	126,250	

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	September 17, 2024 Date
	Stuart Brunsvold Type or print name of actuary	2307622 Most recent enrollment number
	Retirement & Inv. Solutions, CBIZ Firm name	602-277-2371 Telephone number (including area code)
	4722 North 24th Street, Suite 300 Phoenix AZ 85016 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

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** 4

22 Weighted average retirement age **22** 62

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

Part VI Miscellaneous Items

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

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

26 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** 126,250

b Excess assets, if applicable, but not greater than line 31a **31b** 0

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	61,806	5,965
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** 132,215

	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).....			36 132,215
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....			37 139,974

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

a Total (excess, if any, of line 37 over line 36)..... **38a** 7,759

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

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, line 19 – Discounted Employer Contributions

Applicable Year	Contribution	Contribution Date	Interest Rate for Late Quarterly Installments	Effective Interest Rate	Interest Adjusted Contribution
2023	\$118,996	9/6/2024	10.00%	5.00%	\$109,962
2023	\$31,004	9/6/2024	n/a	5.00%	\$30,012
Total	\$150,000				\$139,974

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

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

Retirement Age	Number of Retirees		Age Times Number of Retirees	
62	1.00	X	62.00	
	1.00		$\frac{62.00}{1.00}$	= 62.00

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, Part V – Summary of Plan Provisions

The following summary of plan provisions was used to perform the actuarial valuation as of December 31, 2023.

Effective Date January 1, 2019.

Eligible to Participate Age 21 and 1 Year of Service.

Normal Retirement
Eligibility Age 62.

Benefit Actuarial Equivalent of Participant's Hypothetical Account. The Participant's Hypothetical Account is the sum of the Participant's Hypothetical Allocations and Interest Credits.

Hypothetical Allocations are based on the Allocation Group in which the Participant is classified. For each Plan Year of Service, Hypothetical Allocations are provided to Participants in an amount equal to the following.

The Hypothetical Allocations for each group are as follows: Group A, \$125,000 and Group B, 1.00% of Compensation.

The benefits provided under this Plan shall be no less than the amount needed to provide an Accrued Benefit equal to the Actuarial Equivalent, at Normal Retirement Age, of 0.5% of Compensation for each Plan Year of Service.

Interest Credits are added monthly in an amount equal to one-twelfth (1/12) of 5.0%.

Accrued Benefit A benefit determined by the above formula to the date of determination.

Early Retirement None.

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, Part V – Summary of Plan Provisions

Late Retirement Eligibility	Past Normal Retirement Eligibility.
Benefit	Greater of the Actuarial Equivalent of the Accrued Benefit as of the last day of the prior year or the Accrued Benefit attributable to service both before and after Normal Retirement Date.
Disability Retirement	Actuarial Equivalent of the Accrued Benefit.
Pre-Retirement Death	Actuarial Equivalent of the Accrued Benefit.
Withdrawal Benefit	Actuarial Equivalent of the Accrued Benefit times the Vested Percentage.
Vested Percentage	100% after 3 Years of Service. Years of Service prior to the Effective Date of the Plan are excluded.
Optional Payment Form	Lump Sum.
Normal Payment Form	Life Annuity.
Year of Service	Year with 1,000 or more Hours of Service.
Plan Year of Service	Plan Year in which a Participant completes 1,000 or more Hours of Service.
Actuarial Equivalents	5.00% interest. 2019 Applicable 417(e)(3) Mortality Table. No pre-retirement mortality.
Plan Year	January 1 through December 31.

Changes Since the Prior Valuation

- There were no plan changes since the prior valuation.

ATTACHMENT TO SCHEDULE SB OF FORM 5500

PLAN NAME: Desert Gastroenterology, PLLC Cash Balance Plan

EIN: 82-3050418

PLAN NO.: 002

PLAN YEAR ENDING: December 31, 2023

Schedule SB, line 32 – Schedule of Amortization Bases

Type of Base	Valuation Date Base was Established	Remaining Period (years)	Present Value of Remaining Installments	Amortization Installment
Shortfall Base	12/31/2023	15	(6,793)	(622)
Shortfall Base	12/31/2022	14	68,599	6,587
Total Shortfall			61,806	5,965