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| <div>Form 5500</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security<br/>Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Annual Return/Report of Employee Benefit Plan</div> <div>This form is required to be filed for employee benefit plans 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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div> | <div>OMB Nos. 1210-0110<br/>1210-0089</div> <div>2023</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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: <div><div><input type="checkbox"/> a multiemployer plan</div><div><input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)</div><div><input checked="" type="checkbox"/> a single-employer plan</div><div><input type="checkbox"/> a DFE (specify) _____</div><div><input type="checkbox"/> the first return/report</div><div><input type="checkbox"/> the final return/report</div><div><input type="checkbox"/> an amended return/report</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months)</div></div> |
| C                                                                                          | If the plan is a collectively-bargained plan, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| D                                                                                          | Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558</div><div><input type="checkbox"/> automatic extension</div><div><input type="checkbox"/> the DFVC program</div><div><input type="checkbox"/> special extension (enter description)</div></div>                                                                                                                                                                                                                                                                                                                                                                                                       |
| E                                                                                          | If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|         |                                                                                                                                                                                                                                                                                                                                 |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information—enter all requested information                                                                                                                                                                                                                                                                          |
| 1a      | Name of plan<br>UROLOGY NEVADA, LTD. 401(K) PROFIT SHARING PLAN                                                                                                                                                                                                                                                                 |
| 1b      | Three-digit plan number (PN) ▶ 002                                                                                                                                                                                                                                                                                              |
| 1c      | Effective date of plan<br>07/01/1971                                                                                                                                                                                                                                                                                            |
| 2a      | Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>UROLOGY NEVADA, LTD.<br><br>5560 KIETZKE LANE, BLDG. A<br>RENO, NV 89511 |
| 2b      | Employer Identification Number (EIN)<br>20-8628418                                                                                                                                                                                                                                                                              |
| 2c      | Plan Sponsor's telephone number<br>775-823-8166                                                                                                                                                                                                                                                                                 |
| 2d      | Business code (see instructions)<br>621111                                                                                                                                                                                                                                                                                      |

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 accompanying schedules, statements and attachments, 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. | 10/11/2024 | RICHARD T. GERDTS                                            |
|           | 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 |
| SIGN HERE |                                                   |            |                                                              |
|           | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>3b</b> Administrator's EIN<br><br><b>3c</b> Administrator's telephone number<br><br><div style="background-color: #cccccc; height: 40px; width: 100%;"></div>                                                                                       |
| <b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                                                                                                      |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>5</b> 201                                                                                                                                                                                                                                           |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits .....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... | <div style="background-color: #cccccc; height: 20px; width: 100%;"></div> <b>6a(1)</b> 122<br><b>6a(2)</b> 185<br><b>6b</b> 0<br><b>6c</b> 33<br><b>6d</b> 218<br><b>6e</b> 0<br><b>6f</b> 218<br><b>6g(1)</b> 170<br><b>6g(2)</b> 160<br><b>6h</b> 11 |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>7</b>                                                                                                                                                                                                                                               |

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

2A 2E 2F 2G 2J 2R 2T 3D

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

|                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9a</b> Plan funding arrangement (check all that apply)<br>(1) <input type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor | <b>9b</b> Plan benefit arrangement (check all that apply)<br>(1) <input type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**a Pension Schedules**

- (1) ☒ **R** (Retirement Plan Information)
- (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) ☐ **DCG** (Individual Plan Information) – Number Attached \_\_\_\_\_
- (5) ☐ **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☐ **A** (Insurance Information) – Number Attached 0
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

**Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)**

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             |                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> | 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

|                                                                                                              |                                                                                    |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <div>A</div> <div>Name of plan</div> <div>UROLOGY NEVADA, LTD. 401(K) PROFIT SHARING PLAN</div>              | <div>B</div> <div>Three-digit plan number (PN)</div> <div>▶</div> <div>002</div>   |
| <div>C</div> <div>Plan sponsor's name as shown on line 2a of Form 5500</div> <div>UROLOGY NEVADA, LTD.</div> | <div>D</div> <div>Employer Identification Number (EIN)</div> <div>20-8628418</div> |

Part I

Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1

Information on Persons Receiving Only Eligible Indirect Compensation

- a

Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).....

Yes

x

No
- b

If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b)

Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b)

Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b)

Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b)

Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CERITY PARTNERS, LLC

345 CALIFORNIA STREET  
SAN FRANCISCO, CA 94104

82-3417410

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 26 27                  | NONE                                                                                              | 23510                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

(a) Enter name and EIN or address (see instructions)

WESPAC PLAN SERVICES, LLC

4 ORINDA WAY, SUITE 100-B  
ORINDA, CA 94563

26-2824865

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 13 15 37<br>64 65      | NONE                                                                                              | 21097                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

(a) Enter name and EIN or address (see instructions)

WESPAC ADVISORS, LLC

4 ORINDA WAY, SUITE 100-B  
ORINDA, CA 94563

26-2824668

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 26 27                  | NONE                                                                                              | 19267                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CHARLES SCHWAB TRUST BANK

2360 CORPORATE CIRCLE  
HENDERSON, NC 89074

42-1558009

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 13 15 19<br>37 65      | NONE                                                                                              | 3519                                                                   | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

(a) Enter name and EIN or address (see instructions)

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

(a) Enter name and EIN or address (see instructions)

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

**Part I Service Provider Information (continued)**

**3.** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |

**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|--------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------|
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |

**Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)**  
(complete as many entries as needed)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Financial Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                             |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>2023</b>                                   |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>This Form is Open to Public Inspection</b> |

|                                                                                                          |                                         |                                                                    |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------|
| For calendar plan year 2023 or fiscal plan year beginning <b>01/01/2023</b> and ending <b>12/31/2023</b> |                                         |                                                                    |
| <b>A</b> Name of plan<br><b>UROLOGY NEVADA, LTD. 401(K) PROFIT SHARING PLAN</b>                          | <b>B</b> Three-digit plan number (PN) ▶ | <b>002</b>                                                         |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>UROLOGY NEVADA, LTD.</b>             |                                         |                                                                    |
|                                                                                                          |                                         | <b>D</b> Employer Identification Number (EIN)<br><b>20-8628418</b> |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**1** Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

| Assets                                                                                             |                 | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....                                                      | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                            | <b>1b(1)</b>    | 267657                | 382983          |
| <b>(2)</b> Participant contributions .....                                                         | <b>1b(2)</b>    | 31161                 | 16528           |
| <b>(3)</b> Other .....                                                                             | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:                                                                      |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....   | <b>1c(1)</b>    | 40                    | 79421           |
| <b>(2)</b> U.S. Government securities .....                                                        | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                            |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                         | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....                                                                         | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                         | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....                                                                            | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                               | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                   | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                                | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....                                                                 | <b>1c(8)</b>    | 115973                | 117733          |
| <b>(9)</b> Value of interest in common/collective trusts .....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                    | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                            | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....        | <b>1c(13)</b>   | 5056791               | 6912044         |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) ..... | <b>1c(14)</b>   |                       |                 |
| <b>(15)</b> Other .....                                                                            | <b>1c(15)</b>   | 7102643               | 8707228         |

|                                                                           |              |                       |                 |
|---------------------------------------------------------------------------|--------------|-----------------------|-----------------|
| <b>1d</b> Employer-related investments:                                   |              | (a) Beginning of Year | (b) End of Year |
| (1) Employer securities .....                                             | <b>1d(1)</b> |                       |                 |
| (2) Employer real property .....                                          | <b>1d(2)</b> |                       |                 |
| <b>e</b> Buildings and other property used in plan operation .....        | <b>1e</b>    |                       |                 |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e) .....      | <b>1f</b>    | 12574265              | 16215937        |
| <b>Liabilities</b>                                                        |              |                       |                 |
| <b>g</b> Benefit claims payable .....                                     | <b>1g</b>    |                       |                 |
| <b>h</b> Operating payables .....                                         | <b>1h</b>    |                       |                 |
| <b>i</b> Acquisition indebtedness .....                                   | <b>1i</b>    |                       |                 |
| <b>j</b> Other liabilities .....                                          | <b>1j</b>    |                       |                 |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b>    | 0                     | 0               |
| <b>Net Assets</b>                                                         |              |                       |                 |
| <b>l</b> Net assets (subtract line 1k from line 1f) .....                 | <b>1l</b>    | 12574265              | 16215937        |

**Part II Income and Expense Statement**

**2** Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

|                                                                                                            |                 |            |           |
|------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>Income</b>                                                                                              |                 | (a) Amount | (b) Total |
| <b>a Contributions:</b>                                                                                    |                 |            |           |
| (1) Received or receivable in cash from: (A) Employers .....                                               | <b>2a(1)(A)</b> | 1051542    |           |
| (B) Participants .....                                                                                     | <b>2a(1)(B)</b> | 480257     |           |
| (C) Others (including rollovers) .....                                                                     | <b>2a(1)(C)</b> | 119727     |           |
| (2) Noncash contributions .....                                                                            | <b>2a(2)</b>    |            |           |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            | 1651526   |
| <b>b Earnings on investments:</b>                                                                          |                 |            |           |
| (1) Interest:                                                                                              |                 |            |           |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit) .....              | <b>2b(1)(A)</b> |            |           |
| (B) U.S. Government securities .....                                                                       | <b>2b(1)(B)</b> |            |           |
| (C) Corporate debt instruments .....                                                                       | <b>2b(1)(C)</b> |            |           |
| (D) Loans (other than to participants) .....                                                               | <b>2b(1)(D)</b> | 4666       |           |
| (E) Participant loans .....                                                                                | <b>2b(1)(E)</b> |            |           |
| (F) Other .....                                                                                            | <b>2b(1)(F)</b> |            |           |
| (G) Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                                     | <b>2b(1)(G)</b> |            | 4666      |
| (2) Dividends: (A) Preferred stock .....                                                                   | <b>2b(2)(A)</b> |            |           |
| (B) Common stock .....                                                                                     | <b>2b(2)(B)</b> |            |           |
| (C) Registered investment company shares (e.g. mutual funds) .....                                         | <b>2b(2)(C)</b> |            |           |
| (D) Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....                         | <b>2b(2)(D)</b> |            | 0         |
| (3) Rents .....                                                                                            | <b>2b(3)</b>    |            |           |
| (4) Net gain (loss) on sale of assets: (A) Aggregate proceeds .....                                        | <b>2b(4)(A)</b> |            |           |
| (B) Aggregate carrying amount (see instructions) .....                                                     | <b>2b(4)(B)</b> |            |           |
| (C) Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....                         | <b>2b(4)(C)</b> |            |           |
| (5) Unrealized appreciation (depreciation) of assets: (A) Real estate .....                                | <b>2b(5)(A)</b> |            |           |
| (B) Other .....                                                                                            | <b>2b(5)(B)</b> |            |           |
| (C) Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....                | <b>2b(5)(C)</b> |            |           |

|                                                                                                 |        | (a) Amount | (b) Total |
|-------------------------------------------------------------------------------------------------|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts.....                               | 2b(6)  |            |           |
| (7) Net investment gain (loss) from pooled separate accounts.....                               | 2b(7)  |            |           |
| (8) Net investment gain (loss) from master trust investment accounts.....                       | 2b(8)  |            |           |
| (9) Net investment gain (loss) from 103-12 investment entities.....                             | 2b(9)  |            |           |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) ..... | 2b(10) |            | 2147931   |
| c Other income .....                                                                            | 2c     |            |           |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total .....               | 2d     |            | 3804123   |

**Expenses**

|                                                                                      |        |       |        |
|--------------------------------------------------------------------------------------|--------|-------|--------|
| e Benefit payment and payments to provide benefits:                                  |        |       |        |
| (1) Directly to participants or beneficiaries, including direct rollovers .....      | 2e(1)  | 95058 |        |
| (2) To insurance carriers for the provision of benefits.....                         | 2e(2)  |       |        |
| (3) Other .....                                                                      | 2e(3)  |       |        |
| (4) Total benefit payments. Add lines 2e(1) through (3) .....                        | 2e(4)  |       | 95058  |
| f Corrective distributions (see instructions) .....                                  | 2f     |       |        |
| g Certain deemed distributions of participant loans (see instructions) .....         | 2g     |       |        |
| h Interest expense .....                                                             | 2h     |       |        |
| i Administrative expenses:                                                           |        |       |        |
| (1) Salaries and allowances .....                                                    | 2i(1)  |       |        |
| (2) Contract administrator fees.....                                                 | 2i(2)  |       |        |
| (3) Recordkeeping fees.....                                                          | 2i(3)  | 21097 |        |
| (4) IQPA audit fees.....                                                             | 2i(4)  |       |        |
| (5) Investment advisory and investment management fees .....                         | 2i(5)  | 42777 |        |
| (6) Bank or trust company trustee/custodial fees .....                               | 2i(6)  | 3519  |        |
| (7) Actuarial fees .....                                                             | 2i(7)  |       |        |
| (8) Legal fees .....                                                                 | 2i(8)  |       |        |
| (9) Valuation/appraisal fees .....                                                   | 2i(9)  |       |        |
| (10) Other trustee fees and expenses .....                                           | 2i(10) |       |        |
| (11) Other expenses .....                                                            | 2i(11) |       |        |
| (12) Total administrative expenses. Add lines 2i(1) through (11) .....               | 2i(12) |       | 67393  |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | 2j     |       | 162451 |

**Net Income and Reconciliation**

|                                                          |       |  |         |
|----------------------------------------------------------|-------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d ..... | 2k    |  | 3641672 |
| l Transfers of assets:                                   |       |  |         |
| (1) To this plan .....                                   | 2l(1) |  |         |
| (2) From this plan .....                                 | 2l(2) |  |         |

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **KIMBERLIN COMPANY**

(2) EIN: **45-5497718**

**d** The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

**Part IV Compliance Questions**

**4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

|                                                                                                                                                                                                                                                                                                                  | Yes                                 | No                                  | Amount        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|---------------|
| <b>a</b> 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.) .....                 | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <b>64513</b>  |
| <b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) ..... | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) .....                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) .....                                                                                                                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <b>500000</b> |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                                                                                                   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |               |
| <b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) .....                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. ....                                                                                                                         | <input type="checkbox"/>            | <input type="checkbox"/>            |               |

**5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ..... ☐ Yes ☒ No  
If "Yes," enter the amount of any plan assets that reverted to the employer this year \_\_\_\_\_.

**5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

| <b>5b(1)</b> Name of plan(s) | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> PN(s) |
|------------------------------|---------------------|--------------------|
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |

**5c** Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_\_.

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                  |                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <div>SCHEDULE R</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Retirement Plan Information</div> <div>This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ File as an attachment to Form 5500.</div> | 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 |                                                      |     |
| A Name of plan<br>UROLOGY NEVADA, LTD. 401(K) PROFIT SHARING PLAN                          | B Three-digit plan number (PN) ▶                     | 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>UROLOGY NEVADA, LTD.             | D Employer Identification Number (EIN)<br>20-8628418 |     |

|        |               |
|--------|---------------|
| Part I | Distributions |
|--------|---------------|

All references to distributions relate only to payments of benefits during the plan year.

|   |                                                                                                                                                                                                                                                                                                                               |   |   |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 1 | Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....                                                                                                                                                                                                  | 1 | 0 |
| 2 | Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):<br>EIN(s): 82-3967259 33-6134835<br>Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3. |   |   |
| 3 | Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year .....                                                                                                                                                                                                       | 3 |   |

|         |                                                                                                                                                                        |
|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.) |
|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                      |                                                                                                                                                                                                                                                                                                                                                    |                              |                                        |                              |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------|------------------------------|
| 4                                                    | Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8. |                                                                                                                                                                                                                                                                                                                                                    |                              |                                        |                              |
| 5                                                    | 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 ruling letter granting the waiver. Date: Month _____ Day _____ Year _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                                        |                              |
| 6                                                    | a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....                                                                                                                                                                                                              | 6a                           |                                        |                              |
|                                                      | b Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                | 6b                           |                                        |                              |
|                                                      | c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) .....                                                                                                                                                                                                          | 6c                           |                                        |                              |
| If you completed line 6c, skip lines 8 and 9.        |                                                                                                                                                                                                                                                                                                                                                    |                              |                                        |                              |
| 7                                                    | Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No            | <input type="checkbox"/> N/A |
| 8                                                    | If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? .....                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No            | <input type="checkbox"/> N/A |

|          |            |
|----------|------------|
| Part III | Amendments |
|----------|------------|

|   |                                                                                                                                                                                                                    |                                   |                                   |                               |                             |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| 9 | If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. .... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|         |                                                                                                                                            |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Part IV | ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------|

|    |                                                                                                                                                                                       |                              |                             |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 10 | Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....                                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11 | a Does the ESOP hold any preferred stock? .....                                                                                                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|    | b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12 | Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Part V Additional Information for Multiemployer Defined Benefit Pension Plans**

**13** Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| <b>14</b> Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:<br><b>a</b> The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment) .....<br><b>b</b> The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment) .....<br><b>c</b> The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment) ..... | <b>14a</b><br><br><br><br><br><br><br><b>14b</b><br><br><br><br><br><br><br><b>14c</b> |  |
| <b>15</b> Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |  |
| <b>a</b> The corresponding number for the plan year immediately preceding the current plan year .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>15a</b>                                                                             |  |
| <b>b</b> The corresponding number for the second preceding plan year .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>15b</b>                                                                             |  |
| <b>16</b> Information with respect to any employers who withdrew from the plan during the preceding plan year:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |  |
| <b>a</b> Enter the number of employers who withdrew during the preceding plan year .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>16a</b>                                                                             |  |
| <b>b</b> If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>16b</b>                                                                             |  |
| <b>17</b> If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment..... <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |  |

|                |                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------|
| <b>Part VI</b> | <b>Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans</b> |
|----------------|---------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>18</b> If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment..... <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <b>19</b> If the total number of participants is 1,000 or more, complete lines (a) and (b):<br><b>a</b> Enter the percentage of plan assets held as:<br>Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%<br>High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%<br><b>b</b> Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:<br><input type="checkbox"/> 0-5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> 10-15 years <input type="checkbox"/> 15 years or more                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <b>20 PBGC missed contribution reporting requirements.</b> If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.<br><b>a</b> Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>b</b> If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:<br><input type="checkbox"/> Yes.<br><input type="checkbox"/> No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.<br><input type="checkbox"/> No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.<br><input type="checkbox"/> No. Other. Provide explanation: _____ |  |

|                 |                                 |
|-----------------|---------------------------------|
| <b>Part VII</b> | <b>IRS Compliance Questions</b> |
|-----------------|---------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>21a</b> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>21b</b> 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).<br><input type="checkbox"/> Design-based safe harbor method<br><input type="checkbox"/> "Prior year" ADP test<br><input checked="" type="checkbox"/> "Current year" ADP test<br><input type="checkbox"/> N/A |  |
| <b>22</b> 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 <u>06 / 30 / 2020</u> (MM/DD/YYYY) and the Opinion Letter serial number <u>Q703912A</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**

**FINANCIAL STATEMENTS**

**DECEMBER 31, 2023 AND 2022**

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## **INDEPENDENT AUDITOR'S REPORT**

To the Administrative Committee of:

Urology Nevada, Ltd. 401(k) Profit Sharing Plan  
Reno, Nevada

### **Scope and Nature of the ERISA Section 103(a)(3)(C) Audit**

We have performed an audit of the accompanying financial statements of Urology Nevada, Ltd. 401(k) Profit Sharing Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) [ERISA Section 103(a)(3)(C) audit]. The financial statements comprise the statement of net assets available for benefits as of December 31, 2023 and 2022, and the related statement of changes in net assets available for benefits for the year then ended and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audit of Urology Nevada, Ltd. 401(k) Profit Sharing Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audit need not extend to any statements or information related to assets held for investment of the plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained a certification from a qualified institution as of December 31, 2023 and 2022, and the year ended December 31, 2023 stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

## **Opinion**

In our opinion, based on our audit and on the procedures performed as described in the Auditor's Responsibilities for the Audit of the Financial Statements section—

- the amounts and disclosures in the financial statements referred to above, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- the information in the financial statements referred to above related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

## **Basis for Opinion**

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Urology Nevada, Ltd. 401(k) Profit Sharing Plan and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

## **Responsibilities of Management for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Urology Nevada, Ltd. 401(k) Profit Sharing Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments; administering the plan; and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

## **Auditor's Responsibilities for the Audit of the Financial Statements**

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Urology Nevada, Ltd. 401(k) Profit Sharing Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Urology Nevada, Ltd. 401(k) Profit Sharing Plan ability to continue as a going concern for a reasonable period of time.

Our audit did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

## **Supplemental Schedules Required by ERISA**

The supplemental schedules of assets held at end of year December 31, 2023 and schedule of delinquent participant contributions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, other than the information agreed to or derived from the certified investment information, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion—

- the form and content of the supplemental schedules, other than the information in the supplemental schedules that agreed to or is derived from the certified investment information, are presented, in all material respects, in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.
- the information in the supplemental schedules related to assets held by and certified to by a qualified institution agrees to or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

*Kimberlin Company, PLLC*

August 16, 2024  
Chandler, Arizona

**UROLOGY NEVADA, LTD 401(k) PROFIT SHARING PLAN**  
**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**  
**DECEMBER 31, 2023 AND 2022**

|                                    | <u>2023</u>                 | <u>2022</u>                 |
|------------------------------------|-----------------------------|-----------------------------|
| <b>ASSETS</b>                      |                             |                             |
| Investments (at fair value)        | \$ 15,698,693               | \$ 12,159,474               |
| Receivables:                       |                             |                             |
| Employer contributions             | 382,983                     | 267,657                     |
| Participant contributions          | 16,528                      | 31,161                      |
| Notes receivable from participants | <u>117,733</u>              | <u>115,973</u>              |
| Total receivables                  | <u>517,244</u>              | <u>414,791</u>              |
| Net assets available for benefits  | \$ <u><u>16,215,937</u></u> | \$ <u><u>12,574,265</u></u> |

The Accompanying Notes are an  
Integral Part of these Financial Statements.

**UROLOGY NEVADA, LTD 401(k) PROFIT SHARING PLAN**  
**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**  
**FOR THE YEAR ENDED DECEMBER 31, 2023**

|                                                       | <u>2023</u>                 |
|-------------------------------------------------------|-----------------------------|
| <b>ADDITIONS</b>                                      |                             |
| Investment income:                                    |                             |
| Net appreciation in fair value of investments         | \$ 2,147,931                |
| Interest income on notes receivable from participants | 4,666                       |
| Contributions:                                        |                             |
| Employer                                              | 1,051,542                   |
| Participant                                           | 480,257                     |
| Rollover                                              | <u>119,727</u>              |
| Total contributions                                   | <u>1,651,526</u>            |
| Total additions                                       | 3,804,123                   |
| <b>DEDUCTIONS</b>                                     |                             |
| Benefit payments to participants                      | 95,058                      |
| Administrative fees                                   | <u>67,393</u>               |
| Total deductions                                      | <u>162,451</u>              |
| <b>NET INCREASE</b>                                   | 3,641,672                   |
| <b>NET ASSETS AVAILABLE FOR BENEFITS:</b>             |                             |
| Beginning of year                                     | <u>12,574,265</u>           |
| End of year                                           | \$ <u><u>16,215,937</u></u> |

The Accompanying Notes are an  
Integral Part of these Financial Statements.

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 1 - DESCRIPTION OF THE PLAN**

The following description of the Urology Nevada, Ltd. 401(k) Profit Sharing Plan (the Plan) provides only general information. Participants should refer to the Plan and Trust Agreement (Plan Document) for a more complete description of the Plan's provisions.

*General*

The Plan is a 401(k) profit sharing plan established on July 1, 1971 and covers all eligible employees of Urology Nevada, Ltd. (Plan Sponsor or Company). Employees are eligible to participate in the Plan once they have attained the age of twenty-one and completed two months of service. Plan entry dates are the first day of the month following obtaining eligibility. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Sponsor is the administrator of the Plan.

*Contributions*

Participants may make voluntary salary reductions (participant contributions) up to the maximum amount allowed by the IRS. For 2023 the deferral limit was \$22,500. Participants may also rollover amounts from other qualified plans. Participants over the age of 50 are eligible for catch up contributions.

The Company may make discretionary profit sharing contributions to the Plan, an amount determined by resolution of the owner or other governing authority of the Company. Participants employed on the last day of the Plan year are eligible to receive discretionary profit sharing contributions once they have completed 1,000 hours of service. During 2023, the Company made profit sharing contributions of approximately \$1,110,000.

*Participant Accounts*

Individual accounts are maintained to record participant contributions, rollover contributions, discretionary profit sharing contributions, and earnings thereon for each participant. The benefit to which a participant is entitled is the total benefit, which can be provided from the vested portion of these individual accounts.

*Vesting*

Upon entry into the Plan, participants are 100 percent vested in their salary deferral contributions, rollover contributions, discretionary profit sharing contributions, and earnings thereon. Vesting for the qualified matching contributions and earnings thereon is based on years of service as follows:

| <u>Years of<br/>Service</u> | <u>Vesting<br/>Percentage</u> |
|-----------------------------|-------------------------------|
| 1                           | 0%                            |
| 2                           | 20%                           |
| 3                           | 40%                           |
| 4                           | 60%                           |
| 5                           | 80%                           |
| 6                           | 100%                          |

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 1 - DESCRIPTION OF THE PLAN, CONTINUED**

*Notes Receivable from Participants*

Participants may borrow from their accounts. The amounts borrowed are limited to the lesser of \$50,000 or one half of the participant's vested account balance and must be greater than \$1,000. Loans must bear a reasonable rate of interest and must be repaid within five years.

*Payment of Benefits*

On termination of service due to death, disability, or retirement, a participant may request a distribution of their vested account balance from the Plan Administrator. Furthermore, upon approval of the Plan Administrator, participants may be entitled to take hardship distributions. Participants may elect to withdraw all, or a portion of their account while still employed, upon attainment of age 59 ½. Vested account balances less than \$5,000 for terminated participants will be distributed as soon as administratively feasible after termination. Benefits are recorded when paid.

*Forfeited Accounts*

Forfeited accounts will be used to either pay Plan expenses or to reduce Company contributions. As of December 31, 2023 and 2022, the Plan had a forfeiture balance of approximately \$16,000 and \$0, respectively. During 2023, the Plan used approximately \$58,000 to reduce Company contributions. No forfeitures were used to pay Plan expenses.

*Subsequent Event*

Management has evaluated subsequent events through August 19, 2024, the date the financial statements were available to be issued.

**NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

*Basis of Accounting*

The financial statements of the plan are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

*Estimates*

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

*Notes Receivable from Participants*

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Delinquent notes receivable from participants are recorded as a distribution based upon the terms of the plan document.

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, CONTINUED**

*Investment Valuation and Income Recognition*

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the plan's gains and losses on investments bought and sold as well as held during the year.

*Fair Value Measurements*

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

*Administrative Expenses*

All expenses of maintaining the Plan are paid out of the Plan assets or by the Plan Sponsor. Investment-related expenses are included in net appreciation of fair value of investments.

*Market Risk*

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

**NOTE 3 – INFORMATION PREPARED AND CERTIFIED BY CUSTODIAN**

The Plan administrator has elected the method of annual reporting compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Charles Schwab Bank (Schwab), the custodian of the Plan, has supplied the Plan administrator with a certification as to the completeness and accuracy of all investment and notes receivable from participants information reflected on the accompanying statements of net assets available for benefits as of December 31, 2023 and 2022, the statement of changes in net assets available for benefits for the year ended December 31, 2023, and the supplemental schedule of assets (held at the end of year) as of December 31, 2023.

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 4 – FAIR VALUE MEASUREMENTS**

FASB ASC 820, *Fair Value Measurements and Disclosures*, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobserved inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

- Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
- Level 2: Inputs to the valuation methodology include:
- Quoted prices for similar assets or liabilities in active markets;
  - Quoted prices for identical or similar assets or liabilities in inactive markets;
  - Inputs other than quoted prices that are observable for the asset or liability;
  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

- Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurements.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

*Cash:* Valued at cost basis.

*Self-directed brokerage accounts (SDBA):* Accounts primarily consist of cash, mutual funds, unit investment trusts and common stocks that are valued on the basis of readily determinable market prices.

*Mutual funds:* Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 4 – FAIR VALUE MEASUREMENTS, CONTINUED**

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31:

| <b>2023</b>       |               |         |         |               |
|-------------------|---------------|---------|---------|---------------|
|                   | Level 1       | Level 2 | Level 3 | Total         |
| Cash              | \$ 79,421     | \$ -    | \$ -    | \$ 79,421     |
| SDBA              | 8,707,228     | -       | -       | 8,707,228     |
| Mutual funds      | 6,912,044     | -       | -       | 6,912,044     |
| Total investments | \$ 15,698,693 | \$ -    | \$ -    | \$ 15,698,693 |

| <b>2022</b>       |               |         |         |               |
|-------------------|---------------|---------|---------|---------------|
|                   | Level 1       | Level 2 | Level 3 | Total         |
| Cash              | \$ 40         | \$ -    | \$ -    | \$ 40         |
| SDBA              | 7,102,643     | -       | -       | 7,102,643     |
| Mutual funds      | 5,056,791     | -       | -       | 5,056,791     |
| Total investments | \$ 12,159,474 | \$ -    | \$ -    | \$ 12,159,474 |

**NOTE 5 - TAX STATUS**

The Plan has received an opinion letter from the Internal Revenue Service dated June 30, 2020 stating that the written form of the underlying volume submitter profit sharing plan document is qualified under Section 401(a) of the Internal Revenue Code (the Code), and that any employer adopting this form of the Plan will be considered to have a plan qualified under Section 401(a) of the Code. Once qualified, the Plan is required to operate in conformity with the Code to maintain its qualification. The plan administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes that the Plan is qualified and the related trust is tax exempt.

The Plan follows the provisions of ASC 740, Income Taxes of the FASB Accounting Standards Codification. The Plan believes it has no uncertain tax positions that qualify for either recognition or disclosure. As of December 31, 2023, due to statutes of limitations, the Plan is no longer subject to examination of its 5500 by the IRS for years prior to 2020.

**NOTE 6 – PLAN TERMINATION**

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue their contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants will become 100 percent vested in their accounts.

**UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

**NOTE 7 – PARTY-IN-INTEREST TRANSACTIONS**

The Plan's assets are held by Schwab. Wespac Plan Services, LLC performs the recordkeeping and Plan administration. Wespac Advisors, LLC provides investment advising for the Plan. Therefore, any investment or recordkeeping fees paid during the year to these parties qualify as party-in-interest transactions.

**NOTE 8 – DELINQUENT CONTRIBUTIONS**

During 2023, the Company remitted employee contributions for nine pay periods after the date required during the year by the Department of Labor. The Company will calculate and contribute lost earnings in 2024.

**UROLOGY NEVADA, LTD 401(k) PROFIT SHARING PLAN**  
**SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS HELD AT END OF YEAR**  
**DECEMBER 31, 2023**  
**EIN: 20-8628418**  
**PLAN: 002**

| (a) | (b) Identity of issue, borrower,<br>lessor, or similar party | (c) Description of investment including<br>maturity date, rate of interest, collateral, par,<br>or current value | (d) Cost | (e) Current<br>Value |
|-----|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------|----------------------|
| 1   | Charles Schwab Bank                                          | Cash                                                                                                             | **       | \$ 79,421            |
|     | Self-Directed Brokerage Accounts:                            |                                                                                                                  |          |                      |
| 2   | *Charles Schwab Bank                                         | SDBA                                                                                                             | **       | 8,707,228            |
|     | Mutual Funds:                                                |                                                                                                                  |          |                      |
| 3   | Charles Schwab Bank                                          | American Funds 2010 Target Date Retr Fund                                                                        | **       | 933,274              |
| 4   | Charles Schwab Bank                                          | American Funds 2020 Target Date Retr Fund                                                                        | **       | 31,267               |
| 5   | Charles Schwab Bank                                          | American Funds 2025 Target Date Retr Fund                                                                        | **       | 36,020               |
| 6   | Charles Schwab Bank                                          | American Funds 2030 Target Date Retr Fund                                                                        | **       | 891,624              |
| 7   | Charles Schwab Bank                                          | American Funds 2035 Target Date Retr Fund                                                                        | **       | 308,501              |
| 8   | Charles Schwab Bank                                          | American Funds 2040 Target Date Retr Fund                                                                        | **       | 985,695              |
| 9   | Charles Schwab Bank                                          | American Funds 2045 Target Date Retr Fund                                                                        | **       | 557,400              |
| 10  | Charles Schwab Bank                                          | American Funds 2050 Target Date Retr Fund                                                                        | **       | 645,327              |
| 11  | Charles Schwab Bank                                          | American Funds 2055 Target Date Retr Fund                                                                        | **       | 203,903              |
| 12  | Charles Schwab Bank                                          | American Funds 2060 Target Date Retr Fund                                                                        | **       | 165,203              |
| 13  | Charles Schwab Bank                                          | American Fund Bond Fund of America                                                                               | **       | 54,839               |
| 14  | Charles Schwab Bank                                          | American Funds Europacific Grow                                                                                  | **       | 13,439               |
| 15  | Charles Schwab Bank                                          | Cohen & Steers Realty Shares                                                                                     | **       | 41,613               |
| 16  | Charles Schwab Bank                                          | DFA Emerging Markets Core EQ Port                                                                                | **       | 6,284                |
| 17  | Charles Schwab Bank                                          | Invesco Oppen Senior Float                                                                                       | **       | 135,689              |
| 18  | Charles Schwab Bank                                          | Janus Henderson Triton                                                                                           | **       | 15,475               |
| 19  | Charles Schwab Bank                                          | John Hancock Disciplined Mid Cap                                                                                 | **       | 48,317               |
| 20  | Charles Schwab Bank                                          | JP Morgan Large Cap Growth                                                                                       | **       | 40,266               |
| 21  | Charles Schwab Bank                                          | JP Morgan Equity Income                                                                                          | **       | 80,964               |
| 22  | Charles Schwab Bank                                          | Metropolitan W Total Return Fund                                                                                 | **       | 166                  |
| 23  | Charles Schwab Bank                                          | Parnassus Core Equity Income Fund                                                                                | **       | 16,301               |
| 24  | Charles Schwab Bank                                          | Pimco Income Instl                                                                                               | **       | 127,087              |
| 25  | Charles Schwab Bank                                          | Pimco Short Term Fund                                                                                            | **       | 41,042               |
| 26  | Charles Schwab Bank                                          | Schwab Value Advantage Money Fund                                                                                | **       | 82,689               |
| 27  | Charles Schwab Bank                                          | Undiscovered MGRS BHVRL Value                                                                                    | **       | 17,784               |
| 28  | Charles Schwab Bank                                          | Vanguard 500 Index Admiral                                                                                       | **       | 692,003              |
| 29  | Charles Schwab Bank                                          | Vanguard Mid Cap Index Admiral                                                                                   | **       | 290,059              |
| 30  | Charles Schwab Bank                                          | Vanguard Small Cap Index Admiral                                                                                 | **       | 217,450              |
| 31  | Charles Schwab Bank                                          | Vanguard Total Intl Stk Index                                                                                    |          | 232,363              |
|     |                                                              | Total mutual funds                                                                                               |          | <u>6,912,044</u>     |
|     | Total investments                                            |                                                                                                                  |          | 15,698,693           |
|     |                                                              | Interest rates range from 4.25% to 9.50%                                                                         |          |                      |
|     | * Notes Receivable from Participants                         | Maturing at various times through 2028                                                                           | -0-      | <u>117,733</u>       |
|     | Total                                                        |                                                                                                                  |          | <u>\$ 15,816,426</u> |

\* Indicates a party-in-interest.

\*\* Assets are participant directed investments and, therefore, cost information is not required.

UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN  
SCHEDULE H, LINE 4(a) - SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS  
DECEMBER 31, 2023  
EIN: 20-8628418  
PLAN: 002

| Participant Contributions Transferred<br>Late to Plan                                                        | Total that Constitute Nonexempt Prohibited Transactions |                                            |                                                | Total Fully Corrected<br>Under VFCP and PTE<br>2002-51 |
|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|------------------------------------------------|--------------------------------------------------------|
|                                                                                                              | Contriubtions Not<br>Corrected                          | Contributions<br>Corrected Outside<br>VFCP | Contributions<br>Pending Correction in<br>VFCP |                                                        |
| Check here if Late Participant Loan<br>Repayments are included: <input checked="" type="checkbox"/> \$67,630 | \$ 67,630                                               | (1) \$ -                                   | \$ -                                           | \$ -                                                   |

(1) Represents delinquent participant contributions from ten payroll dates during 2023. The Company plans to remitt lost earnings to the Plan during 2024.

**Form 5500**Department of the Treasury  
Internal Revenue ServiceDepartment of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

This form is required to be filed for employee benefit plans 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.**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

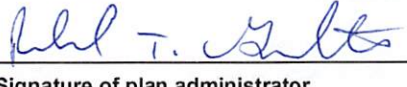
- A** This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan ☐ a DFE (specify) \_\_\_\_\_
- B** This return/report is: ☐ the first return/report ☐ the final return/report
- ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. .... ☐
- D** Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program
- ☐ special extension (enter description) \_\_\_\_\_
- 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**

|                                                                                                                                                                                                                                                                                                                                                  |                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <b>1a</b> Name of plan<br>UROLOGY NEVADA, LTD. 401(k) PROFIT SHARING PLAN                                                                                                                                                                                                                                                                        | <b>1b</b> Three-digit plan number (PN) ▶ 002                 |
|                                                                                                                                                                                                                                                                                                                                                  | <b>1c</b> Effective date of plan<br>07/01/1971               |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br><br>Urology Nevada, Ltd.<br><br>5560 Kietzke Lane, Bldg. A<br><br>Reno NV 89511 | <b>2b</b> Employer Identification Number (EIN)<br>20-8628418 |
|                                                                                                                                                                                                                                                                                                                                                  | <b>2c</b> Plan Sponsor's telephone number<br>775-823-8166    |
|                                                                                                                                                                                                                                                                                                                                                  | <b>2d</b> Business code (see instructions)<br>621111         |

**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 accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

|                  |                                                                                     |                 |                                                              |
|------------------|-------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------|
| <b>SIGN HERE</b> |  | <u>10/11/20</u> | Richard T. Gerdt                                             |
|                  | Signature of plan administrator                                                     | Date            | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |                                                                                     |                 |                                                              |
|                  | Signature of employer/plan sponsor                                                  | Date            | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |                                                                                     |                 |                                                              |
|                  | Signature of DFE                                                                    | Date            | Enter name of individual signing as DFE                      |

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

Form 5500 (2023)  
v. 2300728

**UROLOGY NEVADA, LTD 401(k) PROFIT SHARING PLAN**  
**SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS HELD AT END OF YEAR**  
**DECEMBER 31, 2023**  
**EIN: 20-8628418**  
**PLAN: 002**

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|     |                                                              | Interest rates range from 4.25% to 9.50%                                                                         |          |                      |
|     | * Notes Receivable from Participants                         | Maturing at various times through 2028                                                                           | -0-      | <u>117,733</u>       |
|     | Total                                                        |                                                                                                                  |          | <u>\$ 15,816,426</u> |

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