

<div>Form 5500-SF</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Short Form Annual Return/Report of Small Employee Benefit Plan</div> <div>This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2024</div> <div>This Form is Open to Public Inspection</div>
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 01/01/2021 and ending 06/23/2021	
A	This return/report is for: <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
B	This return/report is <input type="checkbox"/> the first return/report <input checked="" type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input checked="" type="checkbox"/> a short plan year return/report (less than 12 months)
C	Check box if filing under: <input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)
D	If the plan is a collectively-bargained plan, check here ▶ <input type="checkbox"/>
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 PARTNERS IN PRIMARY CARE INC 401(K) PROFIT SHARING PLAN AND TRUST	1b Three-digit plan number (PN) ▶ 002
		1c Effective date of plan 01/01/2005
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) PARTNERS IN PRIMARY CARE INC BRIAN PICKETT 905 PONTIAC AVE CRANSTON, RI 02920-7903	2b Employer Identification Number (EIN) 59-3786697
		2c Sponsor's telephone number 401-464-6617
		2d Business code (see instructions) 812990
3a	Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. PARTNERS IN PRIMARY CARE INC BRIAN PICKETT 905 PONTIAC AVE CRANSTON, RI 02920-7903	3b Administrator's EIN 59-3786697
		3c Administrator's telephone number 401-464-6617
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN 4d PN
5a	Total number of participants at the beginning of the plan year	5a 7
b	Total number of participants at the end of the plan year	5b 0
c(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	5c(1)
c(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c(2) 0
d(1)	Total number of active participants at the beginning of the plan year	5d(1) 5
d(2)	Total number of active participants at the end of the plan year	5d(2) 0
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e 0

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	01/31/2025	BRIAN J PICKETT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/31/2025	BRIAN J PICKETT
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

**Part III Financial Information**

<b>7 Plan Assets and Liabilities</b>		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	1486038	0
<b>b</b> Total plan liabilities .....	<b>7b</b>	0	0
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	1486038	0
<b>8 Income, Expenses, and Transfers for this Plan Year</b>		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>	1400	
<b>(2)</b> Participants .....	<b>8a(2)</b>	4800	
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>	75139	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		81339
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>	1566578	
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>	0	
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>	799	
<b>g</b> Other expenses .....	<b>8g</b>	0	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		1567377
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		-1486038
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>	0	

**Part IV Plan Characteristics**

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
2E 2F 2G 2J 2T 3D 2K
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

**Part V Compliance Questions**

<b>10 During the plan year:</b>		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<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) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>		X	
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

<b>11</b> Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>a</b> Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 .....	<b>11a</b>
<b>b PBGC missed contribution reporting requirements.</b> If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box: <input type="checkbox"/> Yes. <input type="checkbox"/> No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date. <input type="checkbox"/> No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date. <input type="checkbox"/> No. Other. Provide explanation _____	
<b>12</b> Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ..... (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>a</b> If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. .... Month _____ Day _____ Year _____	
<b>If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.</b>	
<b>b</b> Enter the minimum required contribution for this plan year .....	<b>12b</b>
<b>c</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>12c</b>
<b>d</b> Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) .....	<b>12d</b>
<b>e</b> Will the minimum funding amount reported on line 12d be met by the funding deadline?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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

<b>13a</b> Has a resolution to terminate the plan been adopted in any plan year? .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>a</b> If "Yes," enter the amount of any plan assets that reverted to the employer this year.....	<b>13a</b>	
<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>c</b> If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)		
<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

**Part VIII IRS Compliance Questions**

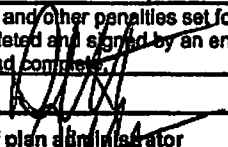
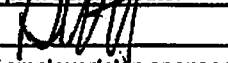
<b>14a</b> Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>14b</b> If this is a Code section 401(k) plan, 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). <input type="checkbox"/> Design-based safe harbor method <input type="checkbox"/> "Prior year" ADP test <input type="checkbox"/> "Current year" ADP test <input type="checkbox"/> N/A	
<b>15</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 ____/____/____ (MM/DD/YYYY) and the Opinion Letter serial number _____.	

<b>Form 5500-SF</b> Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b> This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ <b>Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089 <b>2024</b> <b>This Form Is Open to Public Inspection</b>
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<b>Part I Annual Report Identification Information</b> For calendar plan year 2024 or fiscal plan year beginning 01/01/2021 and ending 06/23/2021	
<b>A</b> This return/report is for: <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)	
<b>B</b> This return/report is: <input type="checkbox"/> the first return/report <input checked="" type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input checked="" type="checkbox"/> a short plan year return/report (less than 12 months)	
<b>C</b> Check box if filing under: <input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)	
<b>D</b> If the plan is a collectively-bargained plan, check here. .... <input type="checkbox"/>	
<b>E</b> If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. .... <input type="checkbox"/>	

<b>Part II Basic Plan Information—enter all requested information</b>															
<b>1a</b> Name of plan PARTNERS IN PRIMARY CARE INC 401(K) PROFIT SHARING PLAN & TRUST	<b>1b</b> Three-digit plan number (PN) ▶ 002 <b>1c</b> Effective date of plan 01/01/2005														
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (Include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Partners In Primary Care Inc 905 PONTIAC AVE CRANSTON RI 02920-7903	<b>2b</b> Employer Identification Number (EIN) 59-3786697 <b>2c</b> Sponsor's telephone number (401)464-6617 <b>2d</b> Business code (see instructions) 812990														
<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. SAME	<b>3b</b> Administrator's EIN <b>3c</b> Administrator's telephone number														
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN <b>4d</b> PN														
<b>5a</b> Total number of participants at the beginning of the plan year ..... <b>b</b> Total number of participants at the end of the plan year ..... <b>c(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)..... <b>c(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... <b>d(1)</b> Total number of active participants at the beginning of the plan year ..... <b>d(2)</b> Total number of active participants at the end of the plan year ..... <b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<table border="1"> <tr><td><b>5a</b></td><td>7</td></tr> <tr><td><b>5b</b></td><td>0</td></tr> <tr><td><b>5c(1)</b></td><td></td></tr> <tr><td><b>5c(2)</b></td><td>0</td></tr> <tr><td><b>5d(1)</b></td><td>5</td></tr> <tr><td><b>5d(2)</b></td><td>0</td></tr> <tr><td><b>5e</b></td><td>0</td></tr> </table>	<b>5a</b>	7	<b>5b</b>	0	<b>5c(1)</b>		<b>5c(2)</b>	0	<b>5d(1)</b>	5	<b>5d(2)</b>	0	<b>5e</b>	0
<b>5a</b>	7														
<b>5b</b>	0														
<b>5c(1)</b>															
<b>5c(2)</b>	0														
<b>5d(1)</b>	5														
<b>5d(2)</b>	0														
<b>5e</b>	0														

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

SIGN HERE		1/31/25	BRIAN J. PICKETT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		1/31/25	BRIAN J. PICKETT
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

**Part III Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets .....	<b>7a</b>	1486038	0
<b>b</b> Total plan liabilities .....	<b>7b</b>	0	0
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	1486038	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers .....	<b>8a(1)</b>	1400	
(2) Participants .....	<b>8a(2)</b>	4800	
(3) Others (including rollovers) .....	<b>8a(3)</b>	0	
<b>b</b> Other income (loss) .....	<b>8b</b>	75139	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		81339
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>	1566578	
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>	0	
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>	799	
<b>g</b> Other expenses .....	<b>8g</b>	0	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		1567377
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		-1486038
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>	0	

**Part IV Plan Characteristics**

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
2E 2F 2G 2J 2T 3D 2K
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

**Part V Compliance Questions**

10 During the plan year:		Yes	No	Amount
<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) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>		X	
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below. ☐ Yes ☒ No

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

**b** PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation \_\_\_\_\_

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above. ☐ Yes ☒ No

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

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

**b** Enter the minimum required contribution for this plan year **12b** 0

**c** Enter the amount contributed by the employer to the plan for this plan year **12c** 0

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

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

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

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

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

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

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

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

**Part VIII IRS Compliance Questions**

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

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

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

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

**Federal Statements**  
**Partners in Primary Care Inc 401(k)Profit Sharing**  
**Plan: 002**

**General Footnote 5500-SF**

**Description**

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IN RESPONSE TO IRS NOTICE CP-406 DATED 01-27-2025

THE SPONSOR OF THIS RETIREMENT PLAN DISCONTINUED OPERATIONS IN 2020.

THE SPONSOR WAS A MEDICAL PRACTICE THAT MERGED WITH A LARGER MEDICAL PRACTICE.

ALL PLAN ASSETS WERE DISBURSED TO THE PLAN PARTICIPANTS.

THE PLAN SPONSOR HAD UTILIZED A THIRD PARTY PAYROLL ADMINISTRATOR TO FILE ALL REQUIRED PLAN FORMS. THE PLAN SPONSOR REQUESTED THAT PAYCHEX FILE A 401(K) PLAN TERMINATION ON 4/11/21 AND ASSUMED THAT IT HAD BEEN COMPLETED AND FILED.

UPON NOTIFICATION FROM THE IRS THAT THEY DID NOT HAVE A FINAL 5500, THE PLAN SPONSOR CONTACTED THEIR CPA FIRM FOR ASSISTANCE. THE CPA FIRM HAS BEEN TRYING TO ELECTRONICALLY FILE THIS FINAL RETURN BUT HAS BEEN UNABLE TO DO SO.

WITH THIS FILING, WE ARE REQUESTING AN ABATEMENT OF ANY PENALTIES RESULTING FROM THIS ACCIDENTAL LATE FILING.

**\*\* IF YOU HAVE ANY QUESTIONS, \*\***  
**\*\* REFER TO THIS INFORMATION: \*\***  
NUMBER OF THIS NOTICE: CP-406  
DATE OF THIS NOTICE: 01-27-2025  
TAXPAYER IDENT. NUM: 59-3786697  
FORM: 5500SF PLAN #: 002  
PLAN YEAR ENDING: 12-31-2022

OGDEN UT 84201-0018

**PARTNERS IN PRIMARY CARE INC**  
**5 ROCKY WAY**  
**WEST KINGSTON RI 02892-1176059**

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**FINAL NOTICE-YOUR ANNUAL FORM 5500 or 5500-SF IS OVERDUE**  
**WRITTEN RESPONSE REQUIRED**

**Why Are You Getting This Notice?**

We did not receive a response, or an explanation as to why you are not required to file, to our previous notice asking you to file Form 5500SF for the plan number and plan year ending indicated below:

Plan Number	Plan Period Ending
002	12-31-2022

If we do not hear from you immediately, we will conclude that you did not intend to file your return and we may take the following actions:

- Ask you to come into our office with your books and records;
- Begin an audit of your plan.

**What You Need To Do**

We urge you to review the items below, complete the appropriate section of the notice and return it to us by 02-27-2025.

1. Complete Section I if you have already filed the return with the Employee Benefits Security Administration (EBSA).
2. Complete Section I if you filed the return using an EIN, plan name, plan number, or plan year ending different from those shown above.
3. Complete Section II if you are not required to file a return file for the plan number and/or plan year ending shown above.
4. If you are required to file a Form 5500 or Form 5500-SF electronically and you need more information, go to [www.efast.dol.gov](http://www.efast.dol.gov).
5. If you are required to file a Form 5500 and have not filed, you may be eligible to participate in the DOL Delinquent Filer Voluntary Compliance Program (DFVCP), which allows for substantially reduced EBSA penalties for delinquent filers and eliminates the IRS penalty. Information about the DFVCP is available on DOL's website, [www.dol.gov/absa](http://www.dol.gov/absa). If you are eligible for and have satisfied the requirements for participation in the DFVCP, check the box below and enter the date that you applied for participation in the DFVCP.



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[ ] DFVC Program Date applied \_\_\_\_\_

#### Penalties for not Filing

If you were required to file and failed to do so, you may be liable under DOL regulations for civil penalties of up to \$2,259 (for 2021) per day for each return/report. In addition, you may be liable for IRS penalties under IRC 6652(e) of \$250 per day (up to a maximum of \$150,000 per plan year on returns required to be filed after December 31, 2019).

#### How to Get Forms, Instructions and Publications

Forms, instructions and publications are available on the IRS website at [www.irs.gov](http://www.irs.gov) or by calling the IRS Forms Distributions Center toll-free at 1-800-TAX-FORM (1-800-829-3676).

#### How To Get Help

For more information about this notice visit the Retirement Plans Community web page at [www.irs.gov/ep](http://www.irs.gov/ep), click on "EP FAQs" in the left Navigational box and click on "Form 5500 Notices - CP 403/406" under Plan Operations or if you need additional information on whom should file refer to Section I of the Form 5500 or Form 5500-SF instructions. If you do not find the information you need, call the IRS Help Line at 1-877-829-5500 (toll free).

#### Response Due Date

Please send the information to us by 02-27-2025.

#### How to Send the Information to Us

Depending on how you respond to this notice, send us the information using one of the following:

1. If you already filed, complete Section I of this notice and send it to the address located in the heading of this notice or fax it to us at 855-214-7520.
2. If you are not required to file, complete Section II of this notice and send it to the address located in the heading of this notice or fax it to us at 855-214-7520.
3. If you are responding to this notice for multiple Plans, please complete the applicable sections for each plan as indicated above.

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COMPLETE AND RETURN WITH YOUR REPLY

Section I

Enter the information exactly as shown on the form filed with EBSA.

Name and address as shown on the form  
Employer Identification  
Number (EIN)

Plan Year Ending

Date filed with EBSA and Acknowledgement Plan Number

Section II

Not Required to File

Please check the box that applies to you, a form was not filed  
because:

- ☐ Plan in question is a Savings Incentive Match Plan for  
Employees of Small Employers (SIMPLE) that involves  
SIMPLE IRAs.
- ☐ Plan in question is a Simplified Employee Pension (SEP).
- ☐ Plan was terminated or merged into a new plan. You must  
still file a "Final" return showing zero end-of-year assets,  
zero participants, and mark "the final return filed for  
the plan" box in part 1 of the form.
- ☐ Other:

Section III

Reason for not filing on time

Explain why you did not file on time: