

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan (checked), 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

1a Name of plan: ADVANTAGE PHYSICIANS HEALTHCARE TRUST; 1b Three-digit plan number (PN): 501; 1c Effective date of plan: 01/01/2023; 2a Plan sponsor's name (employer, if for a single-employer plan): LOUISIANA STATE MEDICAL SOCIETY; 2b Employer Identification Number (EIN): 87-6643571; 2c Plan Sponsor's telephone number: 225-763-2313; 2d Business code (see instructions): 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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor MICHAEL L. WILLIAMS, JR. HUB INTERNATIONAL GULF SOUTH 3510 N CAUSEWAY BLVD SUITE 300 METAIRIE, LA 70006		3b Administrator's EIN 35-0672425
		3c Administrator's telephone number 504-849-7848
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 WILLIAM O QUINLAN c Plan Name ADVANTAGE PHYSICIANS HEALTHCARE TRUST		4b EIN 56-1623293
		4d PN 501
5 Total number of participants at the beginning of the plan year	5	31
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
6a(1) Total number of active participants at the beginning of the plan year	6a(1)	31
6a(2) Total number of active participants at the end of the plan year	6a(2)	152
b Retired or separated participants receiving benefits.....	6b	
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c.....	6d	152
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f Total. Add lines 6d and 6e.....	6f	152
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(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		b General Schedules	
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)	
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> I (Financial Information - Small Plan)	
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>1</u>	
(4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____		(4) <input checked="" type="checkbox"/> C (Service Provider Information)	
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)		(5) <input type="checkbox"/> D (DFE/Participating Plan Information)	
		(6) <input type="checkbox"/> 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 167662904

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan ADVANTAGE PHYSICIANS HEALTHCARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LOUISIANA STATE MEDICAL SOCIETY	D Employer Identification Number (EIN) 87-6643571	

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 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

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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)

HCP NATIONAL INSURANCE SERVICES INC

16-A JOURNEY STE 150
ALISO VIEJO, CA 92656

95-4475799

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	203539	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

LIVE OAK MEWA MANAGEMENT LLC

1115 N CAUSEWAY BLVD STE 100
MANDEVILLE, LA 70471

88-4183577

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
13 19	NONE	156566	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

MCGRIFF

405 E SAINT PETER ST
NEW IBERIA, LA 70560

56-1623293

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
14 22	NONE	100821	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" 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)

BLUE CROSS AND BLUE SHIELD OF LOUIS

5525 REITZ AVE
BATON ROUGE, LA 70809

82-2726860

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
12 23	NONE	78353	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

WINDSOR STRATEGY PARTNERS INC

777 ALEXANDER RD STE 201
PRINCETON, NJ 08540

81-0912547

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	70750	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

STRATEGIC UNDERWRITING SOLUTION

2593 DEVELOPMENT DR
BELLEVUE, WA 54311

42-1144827

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
23	NONE	24000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" 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)

GENOVA BURNS

494 BROAD ST
NEWARK, NJ 07102

22-2940404

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	17433	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

HELENE CERISE LLC

7 COLONIAL CLUB DR
HARAHAN, LA 70123

47-5193958

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	16708	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

RICHARD CPAS, LLC TAXED AS A PARTNE

3421 N CAUSEWAY BLVD STE 601
METAIRIE, LA 70002

82-2560138

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	12500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" 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)

KARL HANSON

3555 LOYOLA DR STE C
KENNER, LA 70065

72-1175669

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	12000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

AAJ COMPUTER SERVICES INC

500 W CYPRESS CREEK RD STE 570
FORT LAUDERDALE, FL 33309

65-0762524

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	11500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

EISNER AMPER LLP TAXED AS PARTNERSH

8550 UNITED PLAZA BLVD STE 1001
BATON ROUGE, LA 70809

92-3320348

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) 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) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	6000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" 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 (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 (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 (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

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(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)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information 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). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan ADVANTAGE PHYSICIANS HEALTHCARE TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOUISIANA STATE MEDICAL SOCIETY	D Employer Identification Number (EIN) 87-6643571

Part I	Asset and Liability Statement
---------------	--------------------------------------

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.

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	173305	65342
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	4305	30342
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1015827	1037180
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	1193437	1132864
Liabilities			
g Benefit claims payable.....	1g	18600	105000
h Operating payables.....	1h	19730	16103
i Acquisition indebtedness.....	1i	1988841	1988841
j Other liabilities.....	1j	58706	11161
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	2085877	2121105
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	-892440	-988241

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.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	1665992	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		1665992
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	22272	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		22272
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		0
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(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)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		1688264

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	956972	
(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)		956972
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)	75000	
(3) Recordkeeping fees	2i(3)	16708	
(4) IQPA audit fees	2i(4)	12500	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	70750	
(8) Legal fees	2i(8)	17433	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	628287	
(11) Other expenses	2i(11)	6415	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		827093
j Total expenses. Add all expense amounts in column (b) and enter total	2j		1784065

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-95801
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: RICHARD CPAS

(2) EIN: 82-2560138

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
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
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.)		X	
c 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.)		X	
d 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.)		X	
e Was this plan covered by a fidelity bond?	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g 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?		X	
h 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?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
j 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.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n 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.		X	

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.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) 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 _____.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

MANDEVILLE, LOUISIANA

FINANCIAL STATEMENTS

DECEMBER 31, 2024

RICHARD  CPAS

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

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Independent Auditors' Report

To the Board of Trustees of
Advantage Physicians Healthcare Trust
Mandeville, Louisiana

Opinion

We have audited the accompanying financial statements of Advantage Physicians Healthcare Trust (a Louisiana trust) (the Trust), which comprise the balance sheets as of December 31, 2024 and 2023, and the related statements of loss, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Advantage Physicians Healthcare Trust as of December 31, 2024 and 2023, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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 Advantage Physicians Healthcare Trust 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 audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

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 the Trust's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

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 the Trust'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 the Trust's ability to continue as a going concern for a reasonable period of time.

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.

Richard CPAS

Metairie, Louisiana
June 9, 2025

ADVANTAGE PHYSICIANS HEALTHCARE TRUST
BALANCE SHEETS
DECEMBER 31, 2024 AND 2023

A S S E T S

	2024	2023
<u>CURRENT ASSETS</u>		
Cash	\$ 996,321	\$ 1,087,871
Receivables	919	2,779
Other assets	29,423	1,526
Total current assets	1,026,663	1,092,176
<u>NON-CURRENT ASSETS</u>		
Certificate of deposit - restricted	106,201	101,261
Total non-current assets	106,201	101,261
<u>TOTAL ASSETS</u>	\$ 1,132,864	\$ 1,193,437

LIABILITIES AND NET ASSETS

<u>CURRENT LIABILITIES</u>		
Accounts payable	\$ 27,264	\$ 19,730
IBNR reserve	105,000	18,600
Commissions payable	-	3,626
Deferred income	-	55,080
Total current liabilities	132,264	97,036
<u>NON-CURRENT LIABILITIES</u>		
Subordinated note payable	1,988,841	1,988,841
Total non-current liabilities	1,988,841	1,988,841
<u>TOTAL LIABILITIES</u>	2,121,105	2,085,877
<u>NET ASSETS</u>		
Net assets	(988,241)	(892,440)
Total net assets	(988,241)	(892,440)
<u>TOTAL LIABILITIES AND NET ASSETS</u>	\$ 1,132,864	\$ 1,193,437

The accompanying notes are an integral part of these financial statements.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST
STATEMENTS OF LOSS
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
<u>OPERATING REVENUES</u>		
Premium income	\$ 1,665,992	\$ 148,913
Total revenues	1,665,992	148,913
 <u>OPERATING EXPENSES</u>		
Claims expense	956,972	115,500
Administrative fees	155,243	93,431
Professional fees	435,730	252,243
Management fees	146,292	13,679
Service agent fees	83,300	7,446
Miscellaneous expenses	6,528	9,316
Total expenses	1,784,065	491,615
 <u>OPERATING LOSS</u>	(118,073)	(342,702)
 <u>NONOPERATING INCOME</u>		
Interest income	22,272	15,531
Total nonoperating income	22,272	15,531
 <u>CHANGE IN NET ASSETS</u>	(95,801)	(327,171)
 <u>NET ASSETS, BEGINNING OF THE YEAR</u>	(892,440)	(565,269)
 <u>NET ASSETS, END OF THE YEAR</u>	\$ (988,241)	\$ (892,440)

The accompanying notes are an integral part of these financial statements.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
<u>CASH FLOWS FROM OPERATING ACTIVITIES</u>		
Change in net assets	\$ (95,801)	\$ (327,171)
Adjustments to reconcile net operating income (loss) to net cash provided by (used in) operating activities:		
(Increase) decrease in receivables	1,860	(2,779)
(Increase) decrease in other assets	(27,897)	(1,526)
Change in accounts payable	7,534	19,730
Change in IBNR reserve	86,400	18,600
Change in commissions payable	(3,626)	3,626
Change in deferred income	(55,080)	55,080
Net cash used in operating activities	<u>(86,610)</u>	<u>(234,440)</u>
<u>CASH FLOWS FROM INVESTING ACTIVITIES</u>		
Change in certificate of deposit	(4,940)	(101,261)
Net cash used in investing activities	<u>(4,940)</u>	<u>(101,261)</u>
<u>CASH FLOWS FROM FINANCING ACTIVITIES</u>		
Drawdown on subordinated note payable	-	134,501
Net cash provided by financing activities	<u>-</u>	<u>134,501</u>
Net change in cash	(91,550)	(201,200)
Cash, beginning of year	<u>1,087,871</u>	<u>1,289,071</u>
Cash, end of year	<u>\$ 996,321</u>	<u>\$ 1,087,871</u>

The accompanying notes are an integral part of these financial statements.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024

1. Summary of Significant Accounting Policies

Background and Organization

The Advantage Physicians Healthcare Trust (the Trust) is established as a self-funded multiple employer welfare arrangement (MEWA) by the Trustees for the benefit of the members of the Louisiana State Medical Society under the applicable laws of the State of Louisiana (R.S. 22:451 et seq.), the Multi-Employer Welfare Act and the Employee Retirement Income Security Act of 1974 to make available health and wellness benefits to those employer members of the Louisiana State Medical Society and employer members of such other not-for-profit associations who elect to join the arrangement for the benefit of their own members and who agree to make contributions in the form of premiums to the Trust to provide for the payment of such benefits.

The Trustees invest and disburse the contributions made by participating employers to provide for the payment of the health and wellness benefits defined for under the Plan(s) on behalf of the employees of the participating employers.

The Trust began operations effective February 1, 2023.

Basis of Accounting

The accompanying financial statements are presented in accordance with U.S. generally accepted accounting principles (GAAP) and prevailing practices within the insurance industry. The Trust utilizes the accrual method of accounting for financial reporting purposes.

Cash and Cash Equivalents

Cash equivalents are all highly liquid investments with maturities of three months or less at date of acquisition.

Premiums and Earned Revenue

Premiums are recognized as premium income the period for which services are covered. Premiums billed and paid in advance of a coverage period are included in deferred revenue.

Unpaid Claims Liability

The Trust provides healthcare insurance coverage to members for claims incurred during the policy period regardless of when the claims are reported to the Trust. The Trust establishes claims liabilities based on estimates of the ultimate cost of claims that have been reported but not settled and of claims that have been incurred but not reported. Because actual claims costs depend on such complex factors the process used in computing claims liability does not necessarily result in an exact amount. Claims liabilities are recomputed periodically using a variety of actuarial and statistical techniques to produce current estimates that reflect recent settlements, claims frequency, and other economic and social factors. Estimated amounts of excess insurance recoverable on unpaid claims are deducted from the liability for unpaid claims.

Adjustments to claims liabilities are charged or credited to claims expense in the periods in which they are made.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024

1. Summary of Significant Accounting Policies (continued)

Excess Insurance Contracts

The Trust enters into excess insurance agreements to reduce its exposure to large losses on insured events. Excess insurance provides for recovery of a portion of losses from third-party insurers, although it does not discharge the primary liability of the Trust as the direct insurer of the insured risks under the coverage agreement. The Trust does not report insured risks as liabilities unless management determines it is probable that those risks will not be covered by the excess insurers.

Use of Estimates

Management of the Trust has made a number of estimates and assumptions relating to the reporting of assets and liabilities to prepare these financial statements in conformity with accounting principles generally accepted in the United States of America. Actual results could differ from those estimates and assumptions. For example, significant estimates and assumptions are used in estimating its unpaid claims liability. If future experience differs materially for these estimates and assumptions, the financial statements could be affected.

Income Tax Status

The Trust provides for income taxes for Federal and State of Louisiana income taxes under Subchapter J Sections 641-644 and 661-664 of the Internal Revenue Code (IRC) and Louisiana Revised Statute 47:181. Under the provisions of these statutes, certain income will be taxed at applicable trust rates on its taxable income less certain expenses and distributions to its employer beneficiaries. The activities of the Trust are not treated as a trade or business. Contributions by employer members are excluded from income.

Investment Valuation and Income Recognition

Certificates of deposit 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. Interest income is recorded on the accrual basis.

2. Claims Expense and Unpaid Claims Liability

Loss development factors for incurred but not reported claims expense are a key assumption underlying many of the actuarial methods utilized. Loss development factors are the ratio of losses at successive evaluations for a defined group of claims expense. Development factors may be dependent on a number of elements, including frequency and severity of claims, length of time to achieve ultimate settlement of claims, projected inflation of medical costs and wages, judicial determinations and existing laws and regulations. The predictive ability of loss development factors is dependent on consistent underwriting, claims handling, among other factors, and predictable legislatively and judicially imposed legal requirements.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024

2. Claims Expense and Unpaid Claims Liability (continued)

The following is information about the incurred and paid claims as of December 31, 2024 and 2023, net of excess insurance, as well as cumulative claim frequency and the total of incurred but not reported liabilities plus expected development on reported claims included within the net incurred claims amount:

Claim Year	Incurred claims and allocated claim adjustment expenses, net of excess insurance	Cumulative Paid	Incurred but not reported plus expected development on reported claims
2023	\$ 115,500	\$ 96,900	\$ 18,600
2024	\$ 956,972	\$ 870,572	\$ 86,400

Liabilities for claims and allocated claims
adjustment expenses, net of excess insurance \$ 105,000

The Trust purchases specific and aggregate excess insurance policies from commercial excess insurers to limit the Trust's losses in excess of specified and aggregate loss limits. The Trust's specific excess policy limits the Trust's losses to the retention amount for any single occurrence, up to a maximum benefit. The Trust's aggregate excess coverage provides protection against losses in the aggregate, subject to a minimum retention by the Trust.

The specific excess insurance obtained from the Trust's inception through December 31, 2024, provides coverage for each and every individual in excess of a \$100,000 retention amount retained by the Trust for claims incurred through June 30, 2025. The individual excess coverage is limited to \$1,000,000. The specific excess insurance provides coverage for all benefits owed to the claimant under the Trust's coverage agreement.

As of December 31, 2024, there are no amounts receivable from the excess insurer for reimbursement of claims paid. No amounts were included as a reduction of the unpaid claims for claims expense incurred in excess of the Trust's retention individual or aggregate levels. The ultimate amount of losses in excess of the Trust's retention has not been determined but unpaid claims expense was estimated to be approximately \$105,000 and \$18,600 at December 31, 2024 and 2023, respectively.

The excess insurance contracts do not relieve the Trust from its obligations to claimants. The Trust remains liable to claimants for the portion insured to the extent that the excess insurer does not meet the obligations assumed under the excess insurance agreement. Failure of the excess insurers to honor their obligation could result in losses to the Trust.

ADVANTAGE PHYSICIANS HEALTHCARE TRUST

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024

3. Subordinated Surplus Note

The Subordinated Surplus Note (Note) is payable to Live Oak MEWA Management LLC. This financing was obtained to fund start-up costs of the Trust.

The Note is unsecured debt subordinated to all claims by members, meaning that in the event of liquidation or bankruptcy, holders of this Note will only be repaid after all obligations of Advantage Physician Healthcare Trust Members, claimants, and beneficiary claims as well as debts owed to all other classes of creditor other than the Note have been satisfied. Payments on the Note can only be made after prior written approval has been granted by the Commissioner of the Louisiana Department of Insurance.

Because of the subordinate nature of the Note and the restriction for payment that requires approval by the Louisiana Department of Insurance Commissioner, under statutory accounting principles, surplus notes are classified as equity. This is different to the presentation in these financial statements in which the Note is classified as a long-term liability on the balance sheets. As of December 31, 2024 and 2023, the Trust had outstanding Subordinated Surplus Notes totaling \$1,988,841.

The Note carries an interest rate of 0%. The outstanding balance is due and payable the earliest of 1) the termination of the management agreement between the Trust and Live Oak MEWA Management LLC, 2) the Trust's surplus as regards to the covered members exceeds the Note balance, or 3) April 30, 2027, but all conditioned on the prior written approval of the Louisiana Department of Insurance Commissioner.

4. Income Taxes

The Trust did not provide for income taxes in 2024 and 2023.

5. Concentrations of Credit Risk

The Trust periodically maintains cash in bank accounts in excess of insured limits. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. At December 31, 2024, the Trust's cash exceeded federally insured limits by \$841,775.

6. Subsequent Events

Management has evaluated subsequent events through the date that the financial statements were available to be issued, June 9, 2025, and determined that there are no items that require additional disclosure. No other subsequent events occurring after this date have been evaluated for inclusion in these financial statements.

Multiple-Employer Welfare Plan Participating Employer Information
ADVANTAGE PHYSICIANS HEALTHCARE TRUST
EIN: 87-6643571 / PN: 501

Name of Participating Employer	EIN	Percent of Total	
		Contributions for Plan	Year
Renal Associates of Baton Rouge LLC	72-1046264		36.14%
Internal Medicine Clinic of Tangipahoa, LLC	03-0417452		11.44%
Williamson Allemond Regional Eye Center	20-5338906		8.58%
Acadiana Otolaryngology Head & Neck Surgery LLC	72-1311785		8.42%
The Skin Surgery Centre	46-2531295		6.49%
Interventional Pain Specialists	26-3942084		5.40%
Center for Women's Health	72-1422492		4.17%
Voitier Group, LLC	46-2281565		3.66%
Family Medical Group, LLC	27-4186709		3.27%
Louisiana State Medical Society	72-0386637		3.11%
Baudry Therapy Center, LLC	26-1156343		2.73%
Family Care Center of SWLA	20-8726057		1.70%
James R Nelson, DDS	46-2947067		1.39%
Degan J Dansereau, MD, LLC	20-1200555		1.09%
Brent Chauvin, DDS	20-4056420		1.00%
James Callaghan, MD, LLC	72-1462648		0.71%
Alta Endocrinology Clinic	88-2237402		0.70%

Form 5500

Department of the Treasury
Internal Revenue Service

Department 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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024


- 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

1a Name of plan ADVANTAGE PHYSICIANS HEALTHCARE TRUST	1b Three-digit plan number (PN) ▶ 501
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) LOUISIANA STATE MEDICAL SOCIETY 5555 HILTON AVE STE 420 BATON ROUGE, LA 70808-2572	1c Effective date of plan 01/01/2023 2b Employer Identification Number (EIN) 87-6643571 2c Plan Sponsor's telephone number 225-763-2313 2d Business code (see instructions) 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		6/30/25	Michael L. Williams, Jr.
	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

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor MICHAEL L. WILLIAMS, JR. HUB INTERNATIONAL GULF SOUTH 3510 N CAUSEWAY BLVD SUITE 300 METAIRIE, LA 70006	3b Administrator's EIN 35-0672425 3c Administrator's telephone number 504-849-7848
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 WILLIAM O QUINLAN c Plan Name ADVANTAGE PHYSICIANS HEALTHCARE TRUST	4b EIN 56-1623293 4d PN 501
5 Total number of participants at the beginning of the plan year	5 31
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 31
a(2) Total number of active participants at the end of the plan year	6a(2) 152
b Retired or separated participants receiving benefits.....	6b
c Other retired or separated participants entitled to future benefits	6c
d Subtotal. Add lines 6a(2), 6b, and 6c.....	6d 152
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e
f Total. Add lines 6d and 6e.....	6f 152
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
 4A

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>1</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 167662904
