

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

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: [X] a single-employer plan [] a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
B This return/report is [] the first return/report [] the final return/report [] an amended return/report [] a short plan year return/report (less than 12 months)
C Check box if filing under: [] Form 5558 [] automatic extension [] DFVC program [] special extension (enter description)
D If the plan is a collectively-bargained plan, check here []
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here []

Part II Basic Plan Information—enter all requested information

1a Name of plan SOUTHERN OREGON HOSPITALISTS, P.C. CASH BALANCE PLAN
1b Three-digit plan number (PN) 002
1c Effective date of plan 01/01/2020
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) SOUTHERN OREGON HOSPITALISTS, P.C.
2640 E BARNETT ROAD, #E333 MEDFORD, OR 97504
2b Employer Identification Number (EIN) 20-2088973
2c Sponsor's telephone number 541-282-6770
2d Business code (see instructions) 621111
3a Plan administrator's name and address [X] Same as Plan Sponsor.
3b Administrator's EIN
3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.
a Sponsor's name SOUTHERN OREGON HOSPITALISTS, PC
c Plan Name SOUTHERN OREGON HOSPITALISTS, PC CASH BALANCE PLAN
4b EIN 20-2088973
4d PN 002
5a Total number of participants at the beginning of the plan year 27
5b Total number of participants at the end of the plan year 32
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)
5d(1) Total number of active participants at the beginning of the plan year 26
5d(2) Total number of active participants at the end of the plan year 30
5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 0

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Row 1: Filed with authorized/valid electronic signature, 07/17/2025, TINO BAUER, MD. Row 2: 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 541646. (See instructions.)

| Part III Financial Information | | | |
|--|--------------|------------------------------|------------------------|
| 7 Plan Assets and Liabilities | | (a) Beginning of Year | (b) End of Year |
| a Total plan assets | 7a | 4653158 | 6548474 |
| b Total plan liabilities | 7b | | |
| c Net plan assets (subtract line 7b from line 7a) | 7c | 4653158 | 6548474 |
| 8 Income, Expenses, and Transfers for this Plan Year | | (a) Amount | (b) Total |
| a Contributions received or receivable from: | | | |
| (1) Employers | 8a(1) | 1533600 | |
| (2) Participants | 8a(2) | | |
| (3) Others (including rollovers) | 8a(3) | | |
| b Other income (loss) | 8b | 374080 | |
| c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | 1907680 |
| d Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | | |
| e Certain deemed and/or corrective distributions (see instructions) . | 8e | | |
| f Administrative service providers (salaries, fees, commissions) | 8f | 12364 | |
| g Other expenses | 8g | | |
| h Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | 12364 |
| i Net income (loss) (subtract line 8h from line 8c) | 8i | | 1895316 |
| j Transfers to (from) the plan (see instructions) | 8j | | |

| 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: <u>1C 3D</u> |
| b | If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: |

| Part V Compliance Questions | | | | |
|---|------------|------------|-----------|---------------|
| 10 During the plan year: | | Yes | No | Amount |
| a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) | 10a | | X | |
| b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | 10b | | X | |
| c Was the plan covered by a fidelity bond? | 10c | X | | 500000 |
| d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | 10d | | X | |
| e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) | 10e | | X | |
| f Has the plan failed to provide any benefit when due under the plan? | 10f | | X | |
| g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) | 10g | | X | |
| h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | 10h | | | |
| i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 | 10i | | | |

Part VI Pension Funding Compliance

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

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 0

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation _____

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

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

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

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

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

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

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

Part VII Plan Terminations and Transfers of Assets

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

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

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

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

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

Part VIII IRS Compliance Questions

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

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

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

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

| | | |
|---|--|--|
| SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection |
|---|--|--|

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

▶ **Round off amounts to nearest dollar.**
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

| | | |
|---|---|------------|
| A Name of plan <u>SOUTHERN OREGON HOSPITALISTS, P.C. CASH BALANCE PLAN</u> | B Three-digit plan number (PN) ▶ | <u>002</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>SOUTHERN OREGON HOSPITALISTS, P.C.</u> | D Employer Identification Number (EIN) <u>20-2088973</u> | |
| E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500 | |

Part I Basic Information

| | | | |
|----------|---|----------------------------|---------------------------|
| 1 | Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2024</u> | | |
| 2 | Assets: | | |
| | a Market value | 2a | <u>4653158</u> |
| | b Actuarial value | 2b | <u>4653158</u> |
| 3 | Funding target/participant count breakdown | (1) Number of participants | (2) Vested Funding Target |
| | a For retired participants and beneficiaries receiving payment | <u>0</u> | <u>0</u> |
| | b For terminated vested participants | <u>1</u> | <u>58090</u> |
| | c For active participants | <u>30</u> | <u>3889857</u> |
| | d Total | <u>31</u> | <u>3947947</u> |
| 4 | If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/> | | |
| | a Funding target disregarding prescribed at-risk assumptions | 4a | |
| | b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor | 4b | |
| 5 | Effective interest rate | 5 | <u>5.13 %</u> |
| 6 | Target normal cost | | |
| | a Present value of current plan year accruals | 6a | <u>1163544</u> |
| | b Expected plan-related expenses | 6b | <u>0</u> |
| | c Target normal cost | 6c | <u>1163544</u> |

Statement by Enrolled Actuary
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

| | | |
|------------------|---|---|
| SIGN HERE | | |
| | Signature of actuary | <u>06/18/2025</u> Date |
| | <u>KIMBERLY A. CORONA</u> Type or print name of actuary | <u>23-06879</u> Most recent enrollment number |
| | <u>CASH BALANCE ACTUARIES, LLC</u> Firm name | <u>952-500-8696</u> Telephone number (including area code) |
| | <u>970 IRIS CIR. EXCELSIOR, MN 55331</u> Address of the firm | |

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

| Part II Beginning of Year Carryover and Prefunding Balances | | (a) Carryover balance | (b) Prefunding balance |
|--|--|-----------------------|------------------------|
| 7 | Balance at beginning of prior year after applicable adjustments (line 13 from prior year) | 0 | 0 |
| 8 | Portion elected for use to offset prior year's funding requirement (line 35 from prior year) | 0 | 0 |
| 9 | Amount remaining (line 7 minus line 8) | 0 | 0 |
| 10 | Interest on line 9 using prior year's actual return of <u>8.49</u> % | 0 | 0 |
| 11 | Prior year's excess contributions to be added to prefunding balance: | | |
| a | Present value of excess contributions (line 38a from prior year) | | 789872 |
| b(1) | Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.27</u> % | | 0 |
| b(2) | Interest on line 38b from prior year Schedule SB, using prior year's actual return | | 0 |
| c | Total available at beginning of current plan year to add to prefunding balance | | 789872 |
| d | Portion of (c) to be added to prefunding balance | | 0 |
| 12 | Other reductions in balances due to elections or deemed elections | 0 | 0 |
| 13 | Balance at beginning of current year (line 9 + line 10 + line 11d – line 12) | 0 | 0 |

| Part III Funding Percentages | | | |
|-------------------------------------|--|-----------|----------|
| 14 | Funding target attainment percentage | 14 | 117.86 % |
| 15 | Adjusted funding target attainment percentage | 15 | 117.86 % |
| 16 | Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement | 16 | 117.79 % |
| 17 | If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage | 17 | % |

| Part IV Contributions and Liquidity Shortfalls | | 18 Contributions made to the plan for the plan year by employer(s) and employees: | | | |
|---|--------------------------------|--|-----------------------|--------------------------------|------------------------------|
| (a) Date (MM-DD-YYYY) | (b) Amount paid by employer(s) | (c) Amount paid by employees | (a) Date (MM-DD-YYYY) | (b) Amount paid by employer(s) | (c) Amount paid by employees |
| 01/30/2024 | 124244 | 0 | 12/30/2024 | 782825 | 0 |
| 02/28/2024 | 124244 | 0 | | | |
| 04/01/2024 | 124244 | 0 | | | |
| 04/30/2024 | 124244 | 0 | | | |
| 05/31/2024 | 123328 | 0 | | | |
| 06/28/2024 | 130471 | 0 | | | |
| Totals ▶ | | | 18(b) | 1533600 | 18(c) 0 |

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

| | | |
|---|------------|---------|
| a Contributions allocated toward unpaid minimum required contributions from prior years | 19a | 0 |
| b Contributions made to avoid restrictions adjusted to valuation date | 19b | 0 |
| c Contributions allocated toward minimum required contribution for current year adjusted to valuation date | 19c | 1484902 |

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? Yes No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? Yes No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

| Liquidity shortfall as of end of quarter of this plan year | | | |
|--|---------|---------|---------|
| (1) 1st | (2) 2nd | (3) 3rd | (4) 4th |
| | | | |

| | | | |
|---|---|--|---|
| Part V Assumptions Used to Determine Funding Target and Target Normal Cost | | | |
| 21 Discount rate: | | | |
| a Segment rates: | 1st segment: 4.75 % | 2nd segment: 4.87 % | <input type="checkbox"/> N/A, full yield curve used |
| b Applicable month (enter code) | | | 21b 1 |
| 22 Weighted average retirement age | | | 22 65 |
| 23 Mortality table(s) (see instructions) | <input checked="" type="checkbox"/> Prescribed - combined | <input type="checkbox"/> Prescribed - separate | <input type="checkbox"/> Substitute |

| | | | |
|---|--|--|-----------|
| Part VI Miscellaneous Items | | | |
| 24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment..... <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 26 Demographic and benefit information | | | |
| a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... | | | 27 |

| | | | |
|---|--|--|-------------|
| Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years | | | |
| 28 Unpaid minimum required contributions for all prior years | | | 28 0 |
| 29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... | | | 29 0 |
| 30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)..... | | | 30 0 |

| | | | |
|--|---------------------|--------------------|--------------------|
| Part VIII Minimum Required Contribution For Current Year | | | |
| 31 Target normal cost and excess assets (see instructions): | | | |
| a Target normal cost (line 6c) | | | 31a 1163544 |
| b Excess assets, if applicable, but not greater than line 31a | | | 31b 705211 |
| 32 Amortization installments: | Outstanding Balance | Installment | |
| a Net shortfall amortization installment | 0 | 0 | |
| b Waiver amortization installment..... | 0 | 0 | |
| 33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount | | | 33 |
| 34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... | | | 34 458333 |
| | Carryover balance | Prefunding balance | Total balance |
| 35 Balances elected for use to offset funding requirement | 0 | 0 | 0 |
| 36 Additional cash requirement (line 34 minus line 35) | | | 36 458333 |
| 37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) | | | 37 1484902 |
| 38 Present value of excess contributions for current year (see instructions) | | | |
| a Total (excess, if any, of line 37 over line 36) | | | 38a 1026569 |
| b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances..... | | | 38b 0 |
| 39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) | | | 39 0 |
| 40 Unpaid minimum required contributions for all years | | | 40 0 |

| | | | |
|---|--|--|--|
| Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions) | | | |
| 41 If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies. <input type="checkbox"/> 2019 <input type="checkbox"/> 2020 <input type="checkbox"/> 2021 | | | |

Southern Oregon Hospitalists, PC
Cash Balance Plan
Actuarial Valuation Date: January 1, 2024
EIN: 20-2088973; Plan Number: 002

Schedule SB, Line 26 - Schedule of Active Participant Data

EXHIBIT 9

I. ACTIVE PARTICIPANTS

| Service/ Age Group | 0-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40 & Over | Total |
|-----------------------|-----|-----|-------|-------|-------|-------|-------|-------|-----------|-------|
| Under 25 | | | | | | | | | | 0 |
| 25-29 | | | | | | | | | | 0 |
| 30-34 | 5 | | | | | | | | | 5 |
| 35-39 | 5 | | | | | | | | | 5 |
| 40-44 | 8 | | | | | | | | | 8 |
| 45-49 | 6 | | | | | | | | | 6 |
| 50-54 | 3 | | | | | | | | | 3 |
| 55-59 | 2 | | | | | | | | | 2 |
| 60-64 | | | | | | | | | | 0 |
| 65 & Over | 1 | | | | | | | | | 1 |
| Totals | 30 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |

II. RECONCILIATION OF PARTICIPANT DATA

| | Category | Actives | Retirees | Disability Retirees | Beneficiaries | Terminated Vested | Total |
|----|------------------------|---------|----------|------------------------|---------------|----------------------|-------|
| a. | Prior Valuation Date | 26 | 0 | 0 | 0 | 1 | 27 |
| b. | New Entrants | 4 | | | | | 4 |
| c. | Terminated | | | | | | 0 |
| d. | Retired | | | | | | 0 |
| e. | Disability | | | | | | 0 |
| f. | Died | | | | | | 0 |
| g. | Rehired | | | | | | 0 |
| h. | Lump Sum Paid Out | | | | | (2) | (2) |
| i. | Terminated No Benefit | | | | | | 0 |
| j. | Adjustment | | | | | 2 | 2 |
| k. | Current Valuation Date | 30 | 0 | 0 | 0 | 1 | 31 |

| |
|--|
| <p>Southern Oregon Hospitalists, PC Cash Balance Plan Actuarial Valuation Date: January 1, 2024 EIN: 20-2088973; Plan Number: 002</p> |
|--|

Appendix B
Schedule SB, Part V - Summary of Actuarial Assumptions and Methods

Investment Return

| <u>Funding Yield Curve Segment Rates</u> | <u>Unadjusted Rates*</u> | <u>Adjusted Rates*</u> |
|--|--------------------------|------------------------|
| 1st Segment | 4.21% | 4.75% |
| 2nd Segment | 4.86% | 4.87% |
| 3rd Segment | 4.87% | 5.59% |
| <u>Other Valuation Rates</u> | | |
| Project Hypothetical Accounts | 4.00% | |
| Salary Scale | 0.00% | |
| Effective Interest Rate | 5.13% | |

Explicit Provision for Expenses

Equal to prior year administrative expenses of \$0.

Assumed Form of Distribution

| | |
|-------------------------|---------|
| Probability of Lump Sum | 100.00% |
| Probability of Annuity | 0.00% |

Mortality Rates

| | <u>Pre-Retirement</u> | <u>Post-Retirement</u> |
|-----------------------|-----------------------|------------------------|
| Funding | None | 2024 Applicable* |
| Actuarial Equivalence | None | 94 GAR-50/50 |

Disability Rates

None.

Withdrawal Rates

None.

Retirement Age

Participants are assumed to retire on the later of (1) the Valuation Date nearest Normal Retirement Date, or (2) the end of the current Plan Year.

Actuarial Value of Assets

Market Value as reported by the sponsor.

Marriage Rates

None.

Changes in Methods or Assumptions

The Plan's actuary and the Valuation Date have changed.

* These assumptions are prescribed by law under IRC Section 430 and are not set at our discretion.

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110
1210-0089

2024

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- D** If the plan is a collectively-bargained plan, check here ▶
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶

Part II Basic Plan Information—enter all requested information

| | | | | | | | | | | | | | | | |
|--|---|-----------|----|-----------|----|--------------|--|--------------|--|--------------|----|--------------|----|-----------|---|
| <p>1a Name of plan Southern Oregon Hospitalists, P.C. Cash Balance Plan</p> | <p>1b Three-digit plan number (PN) ▶ 002</p> | | | | | | | | | | | | | | |
| <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Southern Oregon Hospitalists, P.C. 2640 E Barnett Road, #E333 Medford, OR 97504</p> | <p>1c Effective date of plan 01/01/2020</p> <p>2b Employer Identification Number (EIN) 20-2088973</p> <p>2c Sponsor's telephone number (541) 282-6770</p> <p>2d Business code (see instructions) 621111</p> | | | | | | | | | | | | | | |
| <p>3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.</p> | <p>3b Administrator's EIN</p> <p>3c Administrator's telephone number</p> | | | | | | | | | | | | | | |
| <p>4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name Southern Oregon Hospitalists, PC c Plan Name Southern Oregon Hospitalists, PC Cash Balance Plan</p> | <p>4b EIN 20-2088973</p> <p>4d PN 002</p> | | | | | | | | | | | | | | |
| <p>5a Total number of participants at the beginning of the plan year</p> <p>b Total number of participants at the end of the plan year</p> <p>c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p> <p>c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p> <p>d(1) Total number of active participants at the beginning of the plan year</p> <p>d(2) Total number of active participants at the end of the plan year</p> <p>e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested</p> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">5a</td> <td style="width: 85%; text-align: right;">27</td> </tr> <tr> <td>5b</td> <td style="text-align: right;">32</td> </tr> <tr> <td>5c(1)</td> <td></td> </tr> <tr> <td>5c(2)</td> <td></td> </tr> <tr> <td>5d(1)</td> <td style="text-align: right;">26</td> </tr> <tr> <td>5d(2)</td> <td style="text-align: right;">30</td> </tr> <tr> <td>5e</td> <td style="text-align: right;">0</td> </tr> </table> | 5a | 27 | 5b | 32 | 5c(1) | | 5c(2) | | 5d(1) | 26 | 5d(2) | 30 | 5e | 0 |
| 5a | 27 | | | | | | | | | | | | | | |
| 5b | 32 | | | | | | | | | | | | | | |
| 5c(1) | | | | | | | | | | | | | | | |
| 5c(2) | | | | | | | | | | | | | | | |
| 5d(1) | 26 | | | | | | | | | | | | | | |
| 5d(2) | 30 | | | | | | | | | | | | | | |
| 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 | | 7/17/25 | Tino Bauer, MD |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Yes No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 541646. (See instructions.)

| Part III Financial Information | | | |
|---------------------------------------|---|-----------------------|-----------------|
| 7 | Plan Assets and Liabilities | (a) Beginning of Year | (b) End of Year |
| a | Total plan assets | 4653158 | 6548474 |
| b | Total plan liabilities | | |
| c | Net plan assets (subtract line 7b from line 7a) | 4653158 | 6548474 |
| 8 | Income, Expenses, and Transfers for this Plan Year | (a) Amount | (b) Total |
| a | Contributions received or receivable from: | | |
| | (1) Employers | 1533600 | |
| | (2) Participants | | |
| | (3) Others (including rollovers) | | |
| b | Other income (loss) | 374080 | |
| c | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | | 1907680 |
| d | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | | |
| e | Certain deemed and/or corrective distributions (see instructions) | | |
| f | Administrative service providers (salaries, fees, commissions) | 12364 | |
| g | Other expenses | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | | 12364 |
| i | Net income (loss) (subtract line 8h from line 8c) | | 1895316 |
| j | Transfers to (from) the plan (see instructions) | | |

| 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: 1C 3D |
| b | If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: |

| Part V Compliance Questions | | | | |
|------------------------------------|--|-----|----|--------|
| 10 | During the plan year: | Yes | No | Amount |
| a | Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) | | X | |
| b | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | | X | |
| c | Was the plan covered by a fidelity bond? | X | | 500000 |
| d | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | X | |
| e | Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) | | X | |
| f | Has the plan failed to provide any benefit when due under the plan? | | X | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) | | X | |
| h | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | | |
| i | If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 | | | |

Part VI Pension Funding Compliance

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

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40. **11a** 0

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (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**

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

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

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

Part VII Plan Terminations and Transfers of Assets

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

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

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

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

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

Part VIII IRS Compliance Questions

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

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

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

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

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.


| | | |
|---|---|-----|
| A Name of plan Southern Oregon Hospitalists, P.C. Cash Balance Plan | B Three-digit plan number (PN) ▶ | 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Southern Oregon Hospitalists, P.C. | D Employer Identification Number (EIN) 20-2088973 | |
| E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500 | |

Part I Basic Information

| | | | |
|---|----------------------------|---------------------------|--------------------------|
| 1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2024</u> | | | |
| 2 Assets: | | | |
| a Market value | 2a | 4,653,158 | |
| b Actuarial value | 2b | 4,653,158 | |
| 3 Funding target/participant count breakdown | (1) Number of participants | (2) Vested Funding Target | (3) Total Funding Target |
| a For retired participants and beneficiaries receiving payment | 0 | 0 | 0 |
| b For terminated vested participants | 1 | 58,090 | 58,090 |
| c For active participants | 30 | 3,889,857 | 3,889,857 |
| d Total | 31 | 3,947,947 | 3,947,947 |
| 4 If the plan is in at-risk status, check the box and complete lines (a) and (b) | <input type="checkbox"/> | | |
| a Funding target disregarding prescribed at-risk assumptions | 4a | | |
| b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor | 4b | | |
| 5 Effective interest rate | 5 | 5.13% | |
| 6 Target normal cost | | | |
| a Present value of current plan year accruals | 6a | 1,163,544 | |
| b Expected plan-related expenses | 6b | 0 | |
| c Target normal cost | 6c | 1,163,544 | |

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

| | | | |
|------------------|---|--------------|--|
| SIGN HERE |  | | |
| | Signature of actuary | 06/18/2025 | Date |
| | Kimberly A. Corona | 2306879 | Most recent enrollment number |
| | Cash Balance Actuaries, LLC | 952-500-8696 | Telephone number (including area code) |
| | 970 Iris Cir. | | |
| | Excelsior MN 55331 | | |
| | Address of the firm | | |

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

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

Schedule SB (Form 5500) 2024
v. 240311

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

| | | | | |
|---|--|------------------------|------------------------|---|
| 21 Discount rate: | | | | |
| a Segment rates: | 1st segment: 4.75 % | 2nd segment: 4.87 % | 3rd segment: 5.59 % | <input type="checkbox"/> N/A, full yield curve used |
| b Applicable month (enter code)..... | | | | 21b 1 |
| 22 Weighted average retirement age | | | | 22 65 |
| 23 Mortality table(s) (see instructions) | <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute | | | |

Part VI Miscellaneous Items

| | |
|--|---|
| 24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 26 Demographic and benefit information | |
| a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... | 27 |

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

| | | |
|---|-----------|---|
| 28 Unpaid minimum required contributions for all prior years | 28 | 0 |
| 29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... | 29 | 0 |
| 30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)..... | 30 | 0 |

Part VIII Minimum Required Contribution For Current Year

| | | | |
|--|---------------------|--------------------|---------------|
| 31 Target normal cost and excess assets (see instructions): | | | |
| a Target normal cost (line 6c)..... | 31a | 1,163,544 | |
| b Excess assets, if applicable, but not greater than line 31a | 31b | 705,211 | |
| 32 Amortization installments: | Outstanding Balance | Installment | |
| a Net shortfall amortization installment | 0 | 0 | |
| b Waiver amortization installment | 0 | 0 | |
| 33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount | 33 | | |
| 34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).... | 34 | 458,333 | |
| | Carryover balance | Prefunding balance | Total balance |
| 35 Balances elected for use to offset funding requirement | 0 | 0 | 0 |
| 36 Additional cash requirement (line 34 minus line 35)..... | 36 | 458,333 | |
| 37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)..... | 37 | 1,484,902 | |
| 38 Present value of excess contributions for current year (see instructions) | | | |
| a Total (excess, if any, of line 37 over line 36) | 38a | 1,026,569 | |
| b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances | 38b | 0 | |
| 39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)..... | 39 | 0 | |
| 40 Unpaid minimum required contributions for all years | 40 | 0 | |

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

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

| |
|--|
| <p>Southern Oregon Hospitalists, PC Cash Balance Plan Actuarial Valuation Date: January 1, 2024 EIN: 20-2088973; Plan Number: 002</p> |
|--|

Schedule SB, Line 22 - Description of Weighted Average Retirement Age

All employees are assumed to retire at their Normal Retirement Age or, if later, one year from the valuation date.

The weighted average retirement age is 65.

| Assumed Retirement Age | Participant Count | Weighted Ages |
|---|------------------------------|--------------------------|
| 65 | 29 | 62.8 |
| 66 | 0 | 0.0 |
| 67 | 0 | 0.0 |
| 68 | 0 | 0.0 |
| 69 | 1 | 2.3 |
| Active Participant Count: | | 30 |
| Weighted Average Retirement Age: | | 65 |

Southern Oregon Hospitalists, PC
Cash Balance Plan
Actuarial Valuation Date: January 1, 2024
EIN: 20-2088973; Plan Number: 002

Appendix C
Schedule SB, Part V - Summary of Principal Plan Provisions

Employer and Plan Data

| | |
|------------------------|-------------------|
| Initial Effective Date | January 1, 2020 |
| Plan Year Begins | January 1, 2024 |
| Plan Year Ends | December 31, 2024 |
| Valuation Date | January 1, 2024 |

Eligibility Requirements

| | |
|-----------------|---|
| Service | One Year |
| Entry Dates | Dual |
| Age | 21 |
| Excluded Groups | Collectively Bargained; Nonresident Aliens; Leased Employees; §410(b)(6)(C) Employees; Reclassified Independent Contractors |

Normal Retirement Age

First of the month coincident with or next following the later of age 65 or fifth anniversary of participation.

Retirement Benefits

Actuarial Equivalent of the Participant's Hypothetical Account Balance.

Hypothetical Account

A theoretical account that is maintained for each participant. Each account is credited annually with (a) interest at 4%, plus (b) an allocation following the terms of the Plan Document.

Vesting

100% immediate vesting upon Plan entry.

Death

100% of the Participant's Hypothetical Account.

Disability

100% of the Participant's Hypothetical Account.

Plan Amendments

None.

Southern Oregon Hospitalists, PC
Cash Balance Plan
Actuarial Valuation Date: January 1, 2024
EIN: 20-2088973; Plan Number: 002

Schedule SB, Line 25 - Change in Method

Valuation Date: The valuation date has been changed from the last day of the plan year to the first day of the plan year to allow the annual contribution range to be calculated earlier. This change is not expected to have a material impact on the plan's funding policy.

Asset Valuation Method: No Change

Other: Effective with the 2024 plan year, the Plan's actuary has changed.
In accordance with IRS Revenue Procedure 2017-56, this change qualifies for automatic approval since:

- a. Both the enrolled actuary and the business organization providing actuarial services for the plan are changed.
- b. The new method is substantially the same as the method used by the prior enrolled actuary and is consistent with the description of the method contained in the prior actuarial report or prior Schedule SB.
- c. The funding target and target normal cost (without regard to any adjustments for employee contributions and plan-related expenses), as determined by the new enrolled actuary as of the valuation date for the prior plan year (using the actuarial assumptions of the prior enrolled actuary and using the data elements and valuation software of the new enrolled actuary), are both within 3% of those values as determined for that prior plan year by the prior enrolled actuary.
- d. The actuarial value of plan assets, as determined by the new enrolled actuary as of the valuation date for the prior plan year (using the actuarial assumptions of the prior enrolled actuary), is within 2% of the value for that prior plan year as determined by the prior enrolled actuary.