

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: [X] 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: SOUTHWEST BREAST 401K PLAN
1b Three-digit plan number (PN): 001
1c Effective date of plan: 10/01/2021
2a Plan sponsor's name (employer, if for a single-employer plan): SOUTHWEST BREAST AND AESTHETICS
2b Employer Identification Number (EIN): 86-2161209
2c Sponsor's telephone number: 480-576-4310
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.
4b EIN
4d PN
5a Total number of participants at the beginning of the plan year: 11
5b Total number of participants at the end of the plan year: 11
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item): 11
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item): 11
5d(1) Total number of active participants at the beginning of the plan year: 11
5d(2) Total number of active participants at the end of the plan year: 11
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, Date, and Name. Row 1: JOSEPH ZAKHARY, Signature of plan administrator, 08/20/2025. Row 2: TIM MATATOV, Signature of employer/plan sponsor, 08/20/2025.

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

<b>Part III Financial Information</b>			
<b>7</b> Plan Assets and Liabilities		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	129018	232099
<b>b</b> Total plan liabilities .....	<b>7b</b>	0	0
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	129018	232099
<b>8</b> Income, Expenses, and Transfers for this Plan Year		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>	31342	
<b>(2)</b> Participants .....	<b>8a(2)</b>	50148	
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>	0	
<b>b</b> Other income (loss) .....	<b>8b</b>	26493	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		107983
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>	4902	
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>	0	
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>	0	
<b>g</b> Other expenses .....	<b>8g</b>	0	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		4902
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		103081
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>	0	

<b>Part IV Plan Characteristics</b>	
<b>9a</b>	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2A 2E 2J 2K 2F 2G 3D 3H
<b>b</b>	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

<b>Part V Compliance Questions</b>				
<b>10</b> During the plan year:		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>	X		20000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

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

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

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

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation \_\_\_\_\_

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

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

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

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

**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 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q703912A.

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

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SIGN HERE: Signature of plan administrator, Date: 08/20/2025, Name: JOSEPH ZAKHARY
SIGN HERE: Signature of employer/plan sponsor, Date: 08/20/2025, Name: TIM MATATOV

# Plan Specifications

## Southwest Breast 401k Plan

**For the plan year 1/1/2024 through 12/31/2024**

**Employer:**

**Southwest Breast and Aesthetics**  
 Limited Liability Company (LLC) Taxed as S Corp

EIN: 86-2161209      TIN:      Plan #: 001

**Dates:**

Effective: 10/01/2021      Valuation: 12/31/2024      Year-end: 12/31/2024  
 Period beginning: 01/01/2024 and ending: 12/31/2024

**Eligibility:**

All employees except non-resident aliens, members of an excluded class, union.

Participation

	Minimum Age	Months of Service	Hours Required	Employed on
Profit Sharing	21	12	1000	N/A
Salary Reduction	21	12	1000	N/A
401(k) ADP Safe Harbor Match	21	12	1000	N/A

**Entry Date**

Profit Sharing      First day of 1st or 7th month of plan year on or next following eligibility satisfaction  
 Salary Reduction      First day of 1st or 7th month of plan year on or next following eligibility satisfaction  
 401(k) ADP Safe Harbor Match      First day of 1st or 7th month of plan year on or next following eligibility satisfaction

**Allocation and Vesting:**

Contribution Allocation

Vesting

— Active — — Terminated — — Deceased — — Disabled — — Retired —

	Hours Required	Share	Hours Required	Share	Hours Required	Share	Hours Required	Share	Hours Required	Share
Profit Sharing	1000	Yes	1000	Yes	1000	Yes	1000	Yes	1000	1000
Salary Reduction	0	Yes	0	Yes	0	Yes	0	Yes	0	N/A
401(k) ADP Safe Harbor Match	0	Yes	0	Yes	0	Yes	0	Yes	0	N/A

**Retirement:**

Normal      Attainment of age 65 and completion of 5 years of participation.  
 Early      Not provided

**Contribution Frequency:**

Profit Sharing      Plan Year  
 Salary Reduction      Each Payroll Period  
 401(k) ADP Safe Harbor Match      Plan Year

**Contribution:**

Salary Reduction      At participant's discretion.

Profit Sharing

# Plan Specifications

## Southwest Breast 401k Plan

### For the plan year 1/1/2024 through 12/31/2024

**Contribution: (cont)**

**401(k) ADP Safe Harbor Match**

Graded - Cumulative

Allocation is sum of all levels, based on deferral percent

From	To	Matching Percent
0%	3%	100%
3%	5%	50%

**Limitation Maximums**

§415 Percent of compensation - 100% Dollar amount - \$69,000.00  
 §404(a) Deductible employer contribution - 25% of total compensation  
 §401(a)(17) Compensation - \$345,000.00  
 §402(g) Deferral for calendar year - \$23,000 §414(v) Catch-up - \$7,500

**Vesting:**

**Profit Sharing**

0% In the first year, then 20% per year

Vesting service includes all years of service

All other contribution source accounts are 100% vested at all times.  
 Deceased and disabled participants are immediately 100% vested in all sources.

**Pre-Retirement Death Benefit:** Account Balance

**Discrimination Test Assumptions:**

HCE Determination Based on all employees  
 Otherwise Excludable Otherwise Excludable HCEs are included with the Not Otherwise Excludable employees

**410(b)/401(a)(4) Testing**

Pre-Retirement 8.5% Interest  
 Post-Retirement U84 - 1984 Unisex at 8.5% interest

Permissively Aggregated plans - tested separately  
 Compensation used - Annual Compensation

Testing Service Separate benefiting service for DC and for DB for Accrued-to-Date Method

**ADP/ACP Testing**

401(k) Test Must Pass ADP and ACP Tests  
 NHCE Average Deferral % Based on current year  
 NHCE Average Contribution % Based on current year  
 Shifting ADP shifted to ACP test

**Projection Assumptions:**

Normal Form Lump Sum  
 Pre-Retirement 5% Interest

# SOUTHWEST BREAST 401K PLAN SUMMARY ANNUAL REPORT

EIN 86-2161209  
1/01/2024 TO 12/31/2024

This is a summary annual report for the above plan. The annual report ( Series 5500 ) has been filed with the Internal Revenue Service, as required under the Employee Retirement Income Security Act of 1974 ( ERISA ).

## BASIC FINANCIAL STATEMENT

Benefits under the plan are provided by a trust fund.

Plan expenses for the period were \$ 4,902 . These expenses included \$ 0 in administrative expenses, \$ 4,902 in benefits paid to participants and beneficiaries, and \$ 0 in other expenses. A total of 0 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these people had yet earned the right to receive benefits.

The value of plan assets after subtracting plan liabilities was \$ 129,018 as at the beginning of the year, as compared to \$ 232,099 as at the end of the year. During the plan year, the plan experienced an increase in its assets of \$ 103,081. This change included unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$ 107,983 including employer contributions of \$ 81,490 and earnings from investments of \$ 26,493.

## MINIMUM FUNDING STANDARDS

The Plan is not subject to the minimum funding standards of ERISA.

## YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report or any part thereof, on request. The items below are included in that report :

- Assets held for investment
- Transactions in excess of 3% of plan assets
- Insurance information including sales commissions paid by insurance carriers
- Actuarial information regarding the funding of the plan

To obtain a copy of the full annual report, or any part thereof, write or call the office of the Plan Administrator :

Joseph Zachary  
Southwest Breast and Aesthetics  
2801 E Camelback Rd  
Phoenix AZ 85018  
480-576-4310

The charge to cover copying costs will be \$ 1.25 for the full annual report or \$ 0.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report ( these portions are included without charge.

You also have the legally protected right to examine the annual report at the main office of the plan, at the above address and at the U.S. Department of Labor upon payment of copying costs. Requests to the Department of Labor should be addressed to : Public Disclosure Room, N4677, Pension and Welfare Benefit Programs, Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20216.