

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: 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 <u>ROCKWALL ORAL SURGERY CASH BALANCE PLAN</u>	1b Three-digit plan number (PN) ▶	<u>003</u>
	1c Effective date of plan	<u>01/01/2020</u>
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) <u>G. KEVIN POLLOCK, DDS, MS, PA</u> <u>ROCKWALL ORAL SURGERY</u> <u>960 WEST RALPH HALL PARKWAY</u> <u>ROCKWALL, TX 75032</u>	2b Employer Identification Number (EIN)	<u>75-2935941</u>
	2c Sponsor's telephone number	<u>214-629-9793</u>
	2d Business code (see instructions)	<u>621210</u>
	3a Plan administrator's name and address <input checked="" type="checkbox"/> 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 c Plan Name	4b EIN	
	4d PN	
5a Total number of participants at the beginning of the plan year	5a	<u>9</u>
b Total number of participants at the end of the plan year	5b	<u>9</u>
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	5c(1)	
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c(2)	
d(1) Total number of active participants at the beginning of the plan year	5d(1)	<u>8</u>
d(2) Total number of active participants at the end of the plan year	5d(2)	<u>6</u>
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	<u>0</u>

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	<u>Filed with authorized/valid electronic signature.</u>	<u>10/02/2025</u>	<u>G. KEVIN POLLOCK</u>
	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 _____ (See instructions.)

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	916730	1077974
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	916730	1077974
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	55000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	111765	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		166765
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	2522	
e Certain deemed and/or corrective distributions (see instructions) .	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	2999	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		5521
i Net income (loss) (subtract line 8h from line 8c)	8i		161244
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristics	
9a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1B 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)	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		190000
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		4510
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 09 / 13 / 2023 (MM/DD/YYYY) and the Opinion Letter serial number Q705484A.

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
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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>ROCKWALL ORAL SURGERY CASH BALANCE PLAN</u>	B Three-digit plan number (PN) ▶	<u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>G. KEVIN POLLOCK, DDS, MS, PA</u>	D Employer Identification Number (EIN) <u>75-2935941</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>910220</u>
	b Actuarial value	2b	<u>910220</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>2648</u>
	c For active participants	<u>8</u>	<u>664808</u>
	d Total	<u>9</u>	<u>667456</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>4.96 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>148075</u>
	b Expected plan-related expenses	6b	<u>0</u>
	c Target normal cost	6c	<u>148075</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>09/15/2025</u> Date
	<u>JAMES CAMANN</u> Type or print name of actuary	<u>23-06896</u> Most recent enrollment number
	<u>NOVA 401(K) ASSOCIATES</u> Firm name	<u>713-524-5192</u> Telephone number (including area code)
	<u>10777 NORTHWEST FREEWAY SUITE 440 HOUSTON, TX 77092</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 V Assumptions Used to Determine Funding Target and Target Normal Cost				
21 Discount rate:				
a Segment rates:	1st segment: 4.75 %	2nd segment: 4.96 %	3rd segment: 5.59 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)				21b 0
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 type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Yes <input checked="" 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 148075
b Excess assets, if applicable, but not greater than line 31a				31b 9405
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 138670
	Carryover balance	Prefunding balance	Total balance	
35 Balances elected for use to offset funding requirement	0	90858	90858	
36 Additional cash requirement (line 34 minus line 35)				36 47812
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)				37 47812
38 Present value of excess contributions for current year (see instructions)				
a Total (excess, if any, of line 37 over line 36)				38a 0
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				

Schedule SB, Part V - Statement of Actuarial Assumptions & Methods

Plan Name: Rockwall Oral Surgery Cash Balance Plan
EIN: 75-2935941 PN: 003

The actuary chose all of the valuation assumptions other than those prescribed by law.

Assumption	For Funding	Per Plan	For 417(e)
Interest lookback months	0		2
Interest Discount Rates	First Segment Rate 4.75%	Preretirement 5.00%	First Segment Rate 5.50%
	Second Segment Rate 4.96%	Postretirement 5.50%	Second Segment Rate 5.76%
	Third Segment Rate 5.59%		Third Segment Rate 5.83%
Effective rate	4.96%		
Maximum Deduction Discount Rates	First Segment Rate 4.37%		
	Second Segment Rate 4.96%		
	Third Segment Rate 4.95%		
Effective rate	4.56%		
Turnover	None	N/A	
Preretirement Mortality	None	None	None
Disability	None	N/A	N/A
Future Salary Increases	None	N/A	N/A
Assumed Retirement Age	Normal Retirement	N/A	N/A
Assumed Benefit Form	Percent Assumed Plan Normal Form 0%		
	Percent Assumed Lump Sum 100%		
	Percent Assumed Life Only 0%		
	Percent Assumed Joint and Survivor 0%		
Postretirement Mortality	Male - 24MBLN	2024417e	2024417e
	Female - 24FBLN		
Actuarial Value of Assets	Market Value	N/A	N/A
Expenses	0	N/A	N/A

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
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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 ROCKWALL ORAL SURGERY CASH BALANCE PLAN	B Three-digit plan number (PN) ▶	003
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF G. KEVIN POLLOCK, DDS, MS, PA	D Employer Identification Number (EIN) 75-2935941	

E Type of plan: Single Multiple-A Multiple-B **F** Prior year plan size: 100 or fewer 101-500 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		910220
b Actuarial value	2b		910220
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	2648	2648
c For active participants	8	664808	664808
d Total.....	9	667456	667456
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	4.96	%
6 Target normal cost			
a Present value of current plan year accruals	6a		148075
b Expected plan-related expenses	6b		0
c Target normal cost.....	6c		148075

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 James Camann Type or print name of actuary Nova 401(k) Associates Firm name 10777 Northwest Freeway Suite 440 Houston, TX 77092 Address of the firm	<u>9/15/2025</u> Date 23-06896 Most recent enrollment number (713) 524-5192 Telephone number (including area code)
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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 V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:	1st segment: 4.75 %	2nd segment: 4.96 %	3rd segment: 5.59 %	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code) **21b** 0

22 Weighted average retirement age **22** 65

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate 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 Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment Yes 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. Yes No

b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ... Yes 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	148075
b Excess assets, if applicable, but not greater than line 31a	31b	9405

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	138670
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	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	90858	90858

36 Additional cash requirement (line 34 minus line 35)	36	47812
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	47812

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36)	38a	0
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. 2019 2020 2021

Schedule SB, line 19 - Discounted Employer Contributions

Plan Name: Rockwall Oral Surgery Cash Balance Plan
EIN: 75-2935941 PN: 003

Code	Date	Contribution Amount	Effective Rate	For Months	Quarterly Due	Effective Rate Plus 5%	For Months	Discounted Contribution
C	9/2/2025	31,200.75	4.96	3.45	4/15/2024	9.96	16.58	26,986.28
C	9/2/2025	23,799.25	4.96	6.45	7/15/2024	9.96	13.58	20,825.43
B	9/15/2025	7,401.50	4.96	6.45	7/15/2024	9.96	14.00	6,455.20
B	9/15/2025	31,200.75	4.96	9.45	10/15/2024	9.96	11.00	27,530.08
B	9/15/2025	31,200.75	4.96	12.45	1/15/2025	9.96	8.00	27,852.24
B	9/15/2025	31,516.64	4.96	20.45				29,020.77
Total Cont		55,000.00						47,811.71
Total Bal		101,319.64						90,858.29
Total		156,319.64						138,670.00

Code 'C' is a contribution, 'B' is a balance reduction

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

Plan Name: Rockwall Oral Surgery Cash Balance Plan
EIN: 75-2935941 PN: 003

All active participants are assumed to retire at the later of age 65 and 5 years of participation, or at the end of the current plan year. The weighted average retirement age of the plan is 65.12.

Schedule SB, Part V - Summary of Plan Provisions

Plan Name: Rockwall Oral Surgery Cash Balance Plan EIN: 75-2935941 PN: 003

This summary of plan provisions is intended to be a brief overview of the Plan's provisions and should not be used for purposes of certifying benefits.

Plan effective date January 1, 2020

Last amendment effective date January 1, 2020

Plan Year January 1 to December 31

Eligibility Employees are eligible to enter on the January 1 or July 1 that is coincident with or next following the date the participant completes 12 months of service with 1000 hours and attains the age of 21

Excluded Employees Non-resident aliens with no US income, employees whose employment is governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code Section 7701(a)(46)) and the Employer, leased employees, non-owner HCEs, NHCE dentists

Normal Retirement All participants are eligible to retire upon the later of attainment of age 65 and 5 years of participation.

Normal Retirement Benefit Upon retirement a participant will be entitled to a benefit payable in the normal form which is actuarial equivalent of the hypothetical account balance.

Hypothetical allocation and interest credit of:

Group	Interest	Flat \$
0	5.000%	\$150,000
2	5.000%	\$800

In no event is the benefit greater than the Section 415 limit.

Normal Form A monthly benefit payable for the life of the participant

Accrued Benefit The accrued benefit as of any determination date is based on the balance of a participant's hypothetical account.

Termination Benefit Upon termination for any reason other than death or retirement, a participant shall be entitled to a portion of their accrued benefit, in accordance with the following schedule:

Years of Credit	Percent Vested
1	0
2	0
3	100

Credited years are measured as plan years starting with the plan year of hire. Only years during which a participant is credited with at least 1000 hours of service are counted. Service excludes periods prior to attainment of age 18. Service excludes periods prior to January 1, 2020.