

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: NORTH SCOTTSDALE PEDIATRIC DENTISTRY, PLLC DEFINED BENEFIT PLAN
1b Three-digit plan number (PN): 003
1c Effective date of plan: 01/01/2021
2a Plan sponsor's name (employer, if for a single-employer plan): NORTH SCOTTSDALE PEDIATRIC DENTISTRY
2b Employer Identification Number (EIN): 20-2604435
2c Sponsor's telephone number: 480-607-4949
2d Business code (see instructions): 621210
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: 9
5b Total number of participants at the end of the plan year: 12
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: 6
5d(2) Total number of active participants at the end of the plan year: 7
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, 10/06/2025, HENRY DESPAIN, APA, ERPA, QPA. 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 _____ (See instructions.)

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	245395	297148
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	245395	297148
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	42000	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	11871	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		53871
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	2118	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		2118
i Net income (loss) (subtract line 8h from line 8c)	8i		51753
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: 1A 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	
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? (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 02 / 28 / 2023 (MM/DD/YYYY) and the Opinion Letter serial number Q705279A.

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>NORTH SCOTTSDALE PEDIATRIC DENTISTRY, PLLC DEFINED BENEFIT 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>NORTH SCOTTSDALE PEDIATRIC DENTISTRY</u>	D Employer Identification Number (EIN) <u>20-2604435</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>12</u> Day <u>31</u> Year <u>2024</u>		
2	Assets:		
	a Market value	2a	<u>255148</u>
	b Actuarial value	2b	<u>255148</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>3</u>	<u>2537</u>
	c For active participants	<u>8</u>	<u>173136</u>
	d Total	<u>11</u>	<u>175673</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>5.42 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>105606</u>
	b Expected plan-related expenses	6b	<u>0</u>
	c Target normal cost	6c	<u>105606</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>09/30/2025</u> Date
	<u>GARY J. MEVORAH, EA</u> Type or print name of actuary	<u>23-05055</u> Most recent enrollment number
	<u>C/O MGKS</u> Firm name	<u>602-944-1515</u> Telephone number (including area code)
	<u>7600 N 16TH ST, STE 240 PHOENIX, AZ 85020</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>0.00</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)		48604
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>5.30</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		48604
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	144.92 %
15	Adjusted funding target attainment percentage	15	104.95 %
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	113.60 %
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		
09/12/2025	42000	0					
			Totals ▶	18(b)	42000	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 40479
20	Quarterly contributions and liquidity shortfalls:	
a	Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b	If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: 5.04 %	2nd segment: 5.32 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)			21b 4
22 Weighted average retirement age			22 62
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 105606
b Excess assets, if applicable, but not greater than line 31a			31b 79096
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 26510
	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 26510
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)			37 40479
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)			38a 13969
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			

North Scottsdale Pediatric Dentistry, PLLC
Defined Benefit Plan

Summary of Actuarial Assumptions and Method

Plan Year: 1/1/2024 to 12/31/2024

Valuation Date: 12/31/2024

	For Funding		For 417(e)	For Actuarial Equiv.
	<u>Min</u>	<u>Max</u>		
Interest Rates	Seg 1: 5.04%	5.04%	Seg 1: 5.01%	Pre-Retirement: 5.50%
	Seg 2: 5.32%	5.32%	Seg 2: 5.13%	Post-Retirement: 5.50%
	Seg 3: 5.59%	5.33%	Seg 3: 5.15%	
Applicable Date	08/2024	08/2024	12/2023	
Pre-Retirement				
Turnover	None		None	None
Mortality	None		None	None
Assumed Ret Age	Normal retirement age 62 and 5 years of participation		Normal retirement age 62 and 5 years of participation	Normal retirement age 62 and 5 years of participation
Post-Retirement				
Mortality	Male-2024 Small Plan Static Table – Combined Male Female-2024 Small Plan Static Table – Combined Female		2024 Applicable Mortality Table from Notice 2023-73	2024 Applicable Mortality Table from Notice 2023-73
Assumed Benefit Form For Funding	100% Lump Sum / 0% Normal Form			
Assumed Spouse's Age	Spouse assumed to be the same age as participant			Spouse assumed to be the same age as participant
	Participant is assumed to be married to current spouse at retirement if spouse's date of birth is known			Participant is assumed to be married to current spouse at retirement if spouse's date of birth is known
Calculated Effective Interest Rate	5.42%			
Actuarial Cost Method	The Unit Credit funding method was used as prescribed by the Pension Protection Act. This method sets the funding target equal to the present value of accrued benefits, and sets the normal cost equal to the present value of the benefit accrued in the current year.			

An actuarial value of assets is used for funding purposes. This year the actuarial value of assets is 100.0% of the market value of assets.

Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefits Security Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4085 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. 1510-0010
1510-0009

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
North Scottsdale Pediatric Dentistry, PLLC Defined Benefit Plan

1b Three-digit plan number (PI) 003

1c Effective date of plan 01/01/2021

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)
North Scottsdale Pediatric Dentistry
10005 N. 57th St.
Paradise Valley AZ 85253

2b Employer Identification Number (EIN) 20-2604435

2c Sponsor's telephone number 480-607-4949

2d Business code (see instructions) 621210

3a Plan administrator's name and address 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

4c Plan Name

4d PIN

5a Total number of participants at the beginning of the plan year 9

5b Total number of participants at the end of the plan year 12

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 6

5d(2) Total number of active participants at the end of the plan year 7

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 SP or Schedule MEI 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		01/07/2025	Y. GUYER COHEN D.D.S.
	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

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

- 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	245,395	297,148
b Total plan liabilities.....	7b	0	0
c Net plan assets (subtract line 7b from line 7a).....	7c	245,395	297,148
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	42,000	
(2) Participants.....	8a(2)	0	
(3) Others (including rollovers).....	8a(3)	0	
b Other income (loss).....	8b	11,871	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	8c		53,871
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	2,118	
g Other expenses.....	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		2,118
i Net income (loss) (subtract line 8h from line 8c).....	8i		51,753
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: 1A 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	
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? (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 02/28/2023 (MM/DD/YYYY) and the Opinion Letter serial number Q705279a.

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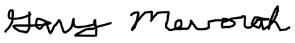
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

▶ **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 North Scottsdale Pediatric Dentistry, PLLC Defined Benefit Plan	B Three-digit plan number (PN) ▶	003
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF North Scottsdale Pediatric Dentistry	D Employer Identification Number (EIN) 20-2604435	
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>12</u>	Day <u>31</u>	Year <u>2024</u>
2 Assets:			
a Market value	2a	255,148	
b Actuarial value	2b	255,148	
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	3	2,537	2,537
c For active participants	8	173,136	173,515
d Total	11	175,673	176,052
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	5.42%	
6 Target normal cost			
a Present value of current plan year accruals	6a	105,606	
b Expected plan-related expenses	6b	0	
c Target normal cost	6c	105,606	

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>9/30/2025</u> Date
	Gary J. Mevorah, EA Type or print name of actuary	<u>2305055</u> Most recent enrollment number
	c/o MGKS Firm name	<u>602-944-1515</u> Telephone number (including area code)
	7600 N 16th St, Ste 240 Phoenix AZ 85020 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**

SUPPLEMENTAL STATEMENT OF ENROLLED ACTUARY
Attached to Schedule SB (Form 5500) 2024

for

North Scottsdale Pediatric Dentistry, PLLC Defined Benefit Plan

EIN: 20-2604435 PN: 003

To the best of my present knowledge, the information contained in the certificate supplemented by this statement is complete and without material error. Although I am not aware of any material inadequacies in the data upon which such certificate is based, such data were furnished by the trustee(s) and the Plan Administrator (and/or by their respective employees, agents, and/or representatives); and, aside from gross tests for overall reasonableness, I have relied on such data in making my valuation; but I do not accept responsibility for the accuracy or inclusiveness of such data.

In addition, I have relied on the Plan Sponsor's legal counsel and the Plan Administrator with respect to the plan's compliance in form and operation with applicable laws and regulations.

Any material change in the foregoing may result in the need to amend the certificate supplemented by this statement.

Gary Mevorah

9/30/25

Gary J. Mevorah, EA

Date

Most Recent Enrollment Number: 23-05055

MGKS
7600 North 16th Street, Ste 240
Phoenix, AZ 85020
(602) 944-1515

Part V Assumptions Used to Determine Funding Target and Target Normal Cost				
21 Discount rate:				
a Segment rates:	1st segment: 5.04 %	2nd segment: 5.32 %	3rd segment: 5.59%	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code).....				21b 4
22 Weighted average retirement age				22 62
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 105,606
b Excess assets, if applicable, but not greater than line 31a				31b 79,096
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 26,510
	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 26,510
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....				37 40,479
38 Present value of excess contributions for current year (see instructions)				
a Total (excess, if any, of line 37 over line 36)				38a 13,969
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				

North Scottsdale Pediatric Dentistry, PLLC
Defined Benefit Plan

Weighted Average Retirement Age

Plan Year: 1/1/2024 to 12/31/2024

Valuation Date: 12/31/2024

Assumed Retirement Age - 100% of the participants are assumed to retire at the date the plan's normal retirement age is attained, which is defined as:

The later of:

Attainment of age 62

Completion of 5 years of participation from entry date

Participants who have passed their Normal Retirement Date as defined above are assumed to retire on the valuation date.

Weighted average retirement age 62

North Scottsdale Pediatric Dentistry, PLLC

Defined Benefit Plan

Summary of Plan Provisions
Plan Year: 1/1/2024 to 12/31/2024
Valuation Date: 12/31/2024

Plan Effective Date	January 1, 2021
Plan Year	From January 1, 2024 to December 31, 2024
Eligibility	All employees not excluded by class are eligible to enter on the January 1 or July 1 coincident with or following the completion of the following requirements: 1 year of service Minimum age 21
Normal Retirement Age	All participants are eligible to retire with their full retirement benefit on the later of the following: Attainment of age 62 Completion of 5 years of participation from entry date
Normal Retirement Benefit	Upon normal retirement each participant will be entitled to a benefit payable in the normal form equal to the following: Group 1: 4.00% of Average Monthly Compensation for each Year of Participation Group 2: 0.5% of Average Annual Compensation for each Year of Credited Service The maximum monthly benefit is the lesser of \$22,916.66 and 100% of the highest 3-year average salary, subject to service requirements. The benefit is based on average salary during the highest 50 consecutive years of service from date of hire.
Normal Form of Benefit	A benefit payable for the life of the participant
Accrued Benefit	The normal retirement benefit described above calculated based on salary and/or service on the calculation date, and payable on the normal retirement date. Credited years are plan years from the first day of the plan year containing date of entry excluding the following: Years with less than 1,000 hours
Termination Benefit	Upon termination for any reason other than death or retirement a participant shall be entitled to a portion of the actuarial equivalent of his accrued benefit in accordance with the following vesting schedule:

Credited Years

Vested Percent

North Scottsdale Pediatric Dentistry, PLLC

Defined Benefit Plan

Summary of Plan Provisions

Plan Year: 1/1/2024 to 12/31/2024

Valuation Date: 12/31/2024

1	0
2	20
3	40
4	60
5	80
6	100

Credited years are plan years from date of hire excluding the following:

Years with less than 1,000 hours

Top-Heavy Minimum Benefit

Top-heavy minimum benefits are provided under another plan of the employer

Top-Heavy Status

A plan is top-heavy if over 60% of the value of all accrued benefits in all of the employer's plans are for the benefit of key employees. A key employee is generally an officer or owner of the company. This plan is currently top-heavy.

Death Benefit

Actuarial Equivalent of the accrued benefit earned to date of death