

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 BROADWAY SPORTS & INTERNAL MEDICINE CASH BALANCE PLAN		1b Three-digit plan number (PN) ▶	002
		1c Effective date of plan	01/01/2022
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) BROADWAY SPORTS & INTERNAL MEDICINE 1600 116TH AVE NE SUITE 202 BELLEVUE, WA 98004		2b Employer Identification Number (EIN)	91-1860476
		2c Sponsor's telephone number	206-215-2288
		2d Business code (see instructions)	621111
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		8
b Total number of participants at the end of the plan year	5b		8
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)		8
d(2) Total number of active participants at the end of the plan year	5d(2)		8
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e		0

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/10/2025	GARY SCHUSTER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/09/2025	GARY SCHUSTER
	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	477488	724106
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	477488	724106
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	200000	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	46618	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		246618
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		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		0
i Net income (loss) (subtract line 8h from line 8c)	8i		246618
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: 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	
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		X	
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 Q705218A.

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>BROADWAY SPORTS & INTERNAL MEDICINE CASH BALANCE PLAN</u>	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>BROADWAY SPORTS & INTERNAL MEDICINE</u>	D Employer Identification Number (EIN) <u>91-1860476</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>524106</u>
	b Actuarial value	2b	<u>524106</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>4442</u>
	c For active participants	<u>7</u>	<u>558981</u>
	d Total	<u>8</u>	<u>563423</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>5.43 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>159589</u>
	b Expected plan-related expenses	6b	<u>0</u>
	c Target normal cost	6c	<u>159589</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>10/09/2025</u>	Date
	<u>SCOTT E. RUEHR, FSA</u>	<u>23-02871</u>	Most recent enrollment number
	<u>SELECT PENSION SERVICES</u>	<u>610-622-5122</u>	Telephone number (including area code)
	<u>2434 MANSFIELD AVENUE</u> <u>DREXEL HILL, PA 19026</u>		
	Address of the firm		

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)		150750
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>5.29</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		150750
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	93.02 %
15	Adjusted funding target attainment percentage	15	99.25 %
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	12.43 %
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		
05/16/2025	25000	0					
07/14/2025	25000	0					
08/04/2025	25000	0					
09/10/2025	125000	0					
			Totals ▶	18(b)	200000	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	187587
20	Quarterly contributions and liquidity shortfalls:		
a	Did the plan have a "funding shortfall" for the prior year?	<input checked="" type="checkbox"/> Yes <input 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 checked="" 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
0	0	0	0

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 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	159589	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	39317	5830	
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	165419	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0
36 Additional cash requirement (line 34 minus line 35)	36	165419	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	187587	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	22168	
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 (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>Broadway Sports & Internal Medicine Cash Balance Plan</u>	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>Broadway Sports & Internal Medicine</u>	D Employer Identification Number (EIN) <u>91-1860476</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		524,106
b Actuarial value.....	2b		524,106
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	4,442	4,442
c For active participants.....	7	558,981	558,981
d Total.....	8	563,423	563,423
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		5.43%
6 Target normal cost			
a Present value of current plan year accruals.....	6a		159,589
b Expected plan-related expenses.....	6b		0
c Target normal cost.....	6c		159,589

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>10/09/2025</u> Date
	<u>Scott E. Ruehr, FSA</u> Type or print name of actuary	<u>2302871</u> Most recent enrollment number
	<u>Select Pension Services</u> Firm name	<u>610-622-5122</u> Telephone number (including area code)
	<u>2434 Mansfield Avenue</u> <u>Drexel Hill PA 19026</u> Address of the firm	

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** 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	159,589
b Excess assets, if applicable, but not greater than line 31a	31b	0

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	39,317	5,830
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	165,419
	Carryover balance	Prefunding balance
35 Balances elected for use to offset funding requirement		0
36 Additional cash requirement (line 34 minus line 35).....	36	165,419
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	187,587

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

a Total (excess, if any, of line 37 over line 36)	38a	22,168
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 15 -

**Reconciliation of differences between valuation results and amounts used to
calculate AFTAP**

Broadway Sports & Internal Medicine Cash Balance Plan

EIN/PN: 91-1860476 / 002

PLAN YEAR ENDED: 12/31/24

The percentage shown on line 15 is equal to the sum of the market value of assets on the valuation date and the discounted value of contributions received for the current plan year after the valuation date, divided by the sum of the current year's funding target and target normal cost.

Schedule SB, line 19 - Discounted Employer Contributions

PLAN:	Broadway Sports & Internal Medicine Cash Balance Plan									
EIN/PN:	91-1860476 / 002									
PYE:	12/31/2024									
									165419.00	
				Required Quarterly Contribution						37219.28
				Effective interest rate (EIR)						5.43%
				Penalty rate (5% fixed)						5.00%
				Plan Year End						12/31/24
				Valuation Date						12/31/24
										ADD'L.
				EIR-						DISCOUNT
DATE OF	AMT. OF	DAYS TO	ADJUSTED	Q1	Q2	Q3	Q4	FOR LATE	FINAL	ADJUSTED
DEPOSIT	DEPOSIT	VAL DATE	DEPOSIT	04/15/24	07/15/24	10/15/24	01/15/25	QUARTERLIES	ADJUSTED	DEPOSIT
05/16/25	25000.00	-136.00	24512.00	25000.00	0.00	0.00	0.00	1155.00	23357.00	
07/14/25	25000.00	-195.00	24304.00	12219.28	12780.73	0.00	0.00	1187.00	23117.00	
08/04/25	25000.00	-216.00	24230.00	0.00	24438.55	561.45	0.00	1119.00	23111.00	
09/10/25	125000.00	-253.00	120501.00	0.00	0.00	36657.83	37219.28	2499.00	118002.00	
	-----		-----	-----	-----	-----	-----	-----	-----	-----
	200000.00		193547.00	37219.28	37219.28	37219.28	37219.28	5960.00	187587.00	

Schedule SB, line 22 –

Weighted average retirement age

Broadway Sports & Internal Medicine Cash Balance Plan

EIN/PN: 91-1860476 / 002

PLAN YEAR ENDED: 12/31/24

It was assumed that all participants will retire at Normal Retirement Age (65), or on current valuation date if later.

Schedule SB, Part V –

Statement of Actuarial Assumptions/Methods

Broadway Sports & Internal Medicine Cash Balance Plan

EIN/PN: 91-1860476 / 002

PLAN YEAR ENDED: 12/31/24

- Funding Method: PPA-mandated actuarial cost method
- Asset valuation method: Market value of assets (no smoothing)
- Assumed retirement age: NRA or current valuation date if later.
- Assumed withdrawal rates: None
- Assumed form of benefit payout: Lump sum benefit
- Type of mortality tables used: Static, combined tables
- Pre-retirement mortality assumption: None
- Assumed future annual salary increases: 0%
- Addition to target normal cost for expenses: None
- Assumed future interest crediting rate: 5%

**Schedule SB, Part V –
Summary of Plan Provisions**

Broadway Sports & Internal Medicine Cash Balance Plan

EIN/PN: 91-1860476 / 002

PLAN YEAR ENDED: 12/31/24

- Eligibility: Age 21 and 1 year of service (dual entry dates).
- Theoretical contributions: Varies by class.
- Compensation: W-2 comp as a participant with add-back of 401k deferrals
- Normal annuity form: Single life annuity
- NRA: Age 65 or 5th anniversary of entry (FDOMCWONF)
- Interest crediting rate: flat 5% per annum
- Vesting: 3-year cliff

Attachment to Schedule SB, line 32 - Amortization Base Information

PLAN:	Broadway Sports & Internal Medicine Cash Balance Plan			
EIN/PN:	91-1860476 / 002			
PYE:	12/31/2024			
Type of Base	PV Remaining Installments	Date Established	Yrs remaining	Amort. Installment
Shortfall	\$229,248	12/31/2022	13	\$23,565
Shortfall	(\$4,699)	12/31/2023	14	(\$459)
Shortfall	(\$185,232)	12/31/2024	15	(\$17,276)
	\$39,317			\$5,830

Schedule SB, line 19 - Discounted Employer Contributions

PLAN:	Broadway Sports & Internal Medicine Cash Balance Plan									
EIN/PN:	91-1860476 / 002									
PYE:	12/31/2024									
							165419.00			
			Required Quarterly Contribution				37219.28			
			Effective interest rate (EIR)				5.43%			
			Penalty rate (5% fixed)				5.00%			
			Plan Year End				12/31/24			
			Valuation Date				12/31/24			
								ADD'L.		
			EIR-					DISCOUNT	FINAL	
DATE OF	AMT. OF	DAYS TO	ADJUSTED	Q1	Q2	Q3	Q4	FOR LATE	ADJUSTED	
DEPOSIT	DEPOSIT	VAL DATE	DEPOSIT	04/15/24	07/15/24	10/15/24	01/15/25	QUARTERLIES	DEPOSIT	
05/16/25	25000.00	-136.00	24512.00	25000.00	0.00	0.00	0.00	1155.00	23357.00	
07/14/25	25000.00	-195.00	24304.00	12219.28	12780.73	0.00	0.00	1187.00	23117.00	
08/04/25	25000.00	-216.00	24230.00	0.00	24438.55	561.45	0.00	1119.00	23111.00	
09/10/25	125000.00	-253.00	120501.00	0.00	0.00	36657.83	37219.28	2499.00	118002.00	
	-----		-----	-----	-----	-----	-----	-----	-----	
	200000.00		193547.00	37219.28	37219.28	37219.28	37219.28	5960.00	187587.00	

Attachment to Schedule SB, line 32 - Amortization Base Information

PLAN:	Broadway Sports & Internal Medicine Cash Balance Plan			
EIN/PN:	91-1860476 / 002			
PYE:	12/31/2024			
Type of Base	PV Remaining Installments	Date Established	Yrs remaining	Amort. Installment
Shortfall	\$229,248	12/31/2022	13	\$23,565
Shortfall	(\$4,699)	12/31/2023	14	(\$459)
Shortfall	(\$185,232)	12/31/2024	15	(\$17,276)
	\$39,317			\$5,830

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

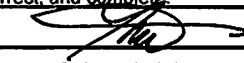

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- 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 Broadway Sports & Internal Medicine Cash Balance Plan	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan 01/01/2022
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) Broadway Sports & Internal Medicine 1600 116th Ave NE Suite 202 Bellevue WA 98004	2b Employer Identification Number (EIN) 91-1860476
	2c Sponsor's telephone number (206) 215-2288
	2d Business code (see instructions) 621111
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
b Total number of participants at the end of the plan year	5b
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)
d(2) Total number of active participants at the end of the plan year	5d(2)
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e

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>10/8/25</u>	Gary Schuster
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		<u>10/8/25</u>	Gary Schuster
	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	477,488	
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	477,488	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)		
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b		
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		0
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		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		0
i Net income (loss) (subtract line 8h from line 8c)	8i		0
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:
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	
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		X	
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 (MM/DD/YYYY) and the Opinion Letter serial number _____

Transmission Log

1

Thursday, 2025-10-09 09:58

2062152289

Date	Time	Type	Job #	Length	Speed	Fax Name/Number	Pgs	Status
2025-10-09	09:57	SCAN	02628	0:32	14400	18568241890 35	1	OK -- V.17 AM31

FOR PLAN ADMINISTRATOR/PLAN SPONSOR USE ONLY

FILING AUTHORIZATION FORM FOR THE FORM 5500/5500-SF

PLAN #	199397
PLAN NAME	Broadway Sports & Internal Medicine Cash Balance Plan
EIN #	n/a
PLAN YEAR ENDING	12/31/2024

Authorization of Retirement Plan Services to Electronically Sign and File

I hereby authorize Retirement Plan Services (RPS) to electronically sign and file the above named return/report through EFAST2. I understand that in granting this authority:

- ◆ I've must manually sign and date page 1 of the Form 5500 and/or page 1 of Form 5500-SF and provide a scanned copy of that signed form to RPS before electronic filing can be initiated
- ◆ RPS will retain a copy of this written authorization in its records;
- ◆ RPS will notify the individual(s) signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOI, IRS or PRGC regarding this annual return/report; and
- ◆ A copy of my signature, as it appears on page 1 of the Form 5500 and/or page 1 of Form 5500-SF, will be included with the return/report by the Department of Labor on the Internet for public disclosure.
- ◆ RPS shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.
- ◆ I agree to pay a fee for this service in the amount of \$300.

Please fax the completed form to (856) 824-1890 or scan and e-mail it to forms@retirementplanservice.com

This authorization is applicable only to the filing for the above-named Plan and applies only for the Plan Year End stated above

PLAN ADMINISTRATOR	→	<i>Gary Schuster</i>
NAME & TITLE	→	<i>Gary Schuster MD / President</i>
DATE	→	<i>10-9-25</i>
EMPLOYER/PLAN SPONSOR (ONLY FILL IN IF NOT PLAN ADMINISTRATOR)		
NAME & TITLE		
DATE		

PLEASE EMAIL MY FORM 5500 TO THE EMAIL ADDRESS PROVIDED BELOW:



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)
B This return/report is [] the first return/report [] the final return/report
C Check box if filing under: [X] Form 5558 [] automatic extension [] DFVC program
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: Broadway Sports & Internal Medicine 401(k) Plan
1b Three-digit plan number (PN): 001
1c Effective date of plan: 01/01/2017
2a Plan sponsor's name (employer, if for a single-employer plan): Broadway Sports & Internal Medicine
2b Employer Identification Number (EIN): 91-1860476
2c Sponsor's telephone number: (206) 215-2288
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: 12
5b Total number of participants at the end of the plan year: 10
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item): 12
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item): 10
5d(1) Total number of active participants at the beginning of the plan year: 8
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.

SIGN HERE: Signature of plan administrator, Date: 10/7/25, Gary Schuster
SIGN HERE: Signature of employer/plan sponsor, Date: 10/7/25, Gary Schuster

- 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	890,081	1,147,652
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	890,081	1,147,652
8. Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	51,695	
(2) Participants	8a(2)	80,286	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	127,631	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		259,612
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,728	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	313	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		2,041
i Net income (loss) (subtract line 8h from line 8c)	8i		257,571
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:
 2A 2E 2F 2G 2J 2K 2T 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		10,000
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		4,200
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
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**

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 06/30/2020 (MM/DD/YYYY) and the Opinion Letter serial number Q702751a.

FILING AUTHORIZATION FORM FOR THE FORM 5500/5500-SF

PLAN #	599397
PLAN NAME	Broadway Sports & Internal Medicine 401(k)
EIN #	
PLAN YEAR ENDING	2024

Authorization of Retirement Plan Services to Electronically Sign and File

I hereby authorize Retirement Plan Services (RPS) to electronically sign and file the above named return/report through EFAST2. I understand that in granting this authority:

- ◆ I/we must manually sign and date page 1 of the Form 5500 and/or page 1 of Form 5500-SF and provide a scanned copy of that signed form to RPS before electronic filing can be initiated
- ◆ RPS will retain a copy of this written authorization in its records;
- ◆ RPS will notify the individual(s) signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS or PBGC regarding this annual return/report; and
- ◆ A copy of my signature, as it appears on page 1 of the Form 5500 and/or page 1 of Form 5500-SF, will be included with the return/report by the Department of Labor on the Internet for public disclosure.
- ◆ RPS shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.
- ◆ I agree to pay a fee for this service in the amount of \$300.

Please fax the completed form to (856) 824-1890 or scan and e-mail it to forms@retirementplanservice.com

This authorization is applicable only to the filing for the above-named Plan and applies only for the Plan Year End stated above.

PLAN ADMINISTRATOR	→	GARY Schwster
NAME & TITLE	→	GARY Schwster, MD / President
DATE	→	10-7-25
EMPLOYER/PLAN SPONSOR (ONLY FILL IN IF NOT PLAN ADMINISTRATOR)		
NAME & TITLE		
DATE		

<input checked="" type="checkbox"/> PLEASE EMAIL MY FORM 5500 TO THE EMAIL ADDRESS PROVIDED BELOW:

FILING AUTHORIZATION FORM FOR THE FORM 5500/5500-SF

PLAN #	599397, 199397
PLAN NAME	Broadway Sports and Internal Medicine
EIN #	
PLAN YEAR ENDING	12/31/2024

Authorization of Retirement Plan Services to Electronically Sign and File

I hereby authorize Retirement Plan Services (RPS) to electronically sign and file the above named return/report through EFAST2. I understand that in granting this authority:

- ◆ I/we must manually sign and date page 1 of the Form 5500 and/or page 1 of Form 5500-SF and provide a scanned copy of that signed form to RPS before electronic filing can be initiated
- ◆ RPS will retain a copy of this written authorization in its records;
- ◆ RPS will notify the individual(s) signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS or PBGC regarding this annual return/report; and
- ◆ A copy of my signature, as it appears on page 1 of the Form 5500 and/or page 1 of Form 5500-SF, will be included with the return/report by the Department of Labor on the Internet for public disclosure.
- ◆ RPS shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.
- ◆ I agree to pay a fee for this service in the amount of \$300.

Please fax the completed form to (856) 824-1890 or scan and e-mail it to forms@retirementplanservice.com

This authorization is applicable only to the filing for the above-named Plan and applies only for the Plan Year End stated above.

PLAN ADMINISTRATOR	→	Gary Schuster
NAME & TITLE	→	Gary Schuster w/ President
DATE	→	10-7-25
EMPLOYER/PLAN SPONSOR (ONLY FILL IN IF NOT PLAN ADMINISTRATOR)		
NAME & TITLE		
DATE		

<input checked="" type="checkbox"/> PLEASE EMAIL MY FORM 5500 TO THE EMAIL ADDRESS PROVIDED BELOW:

Transmission Log

1

Tuesday, 2025-10-07 14:03

2062152289

Date	Time	Type	Job #	Length	Speed	Fax Name/Number	Pgs	Status
2025-10-07	14:00	SCAN	02558	2:42	14400	18568241890 4	6	OK -- V.17 AM31

BROADWAY SPORTS AND INTERNAL MEDICINE

Gary R. Schuster, M.D.
1600 116TH AVE NE SUITE 202
BELLEVUE, WA. 98004
(206) 215-2288 Phone • (206) 215 2289 Fax

FAX

Date: 10/7/25	Fax: 856-824-1890	Phone:
To: BCG		
From: Chris		
RE: Dr Gary Schuster	No. of Pages: 6	
Additional Comments: Form 5500-SF Thank you		

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Front Desk2

From: Front Desk2
Sent: Tuesday, October 7, 2025 1:56 PM
To: pwhite@primepay.com
Cc: kathleen.dunne@retirementplanservice.com
Subject: Form 5500
Attachments: Schuster Form 5500-SF.pdf

Hello,

Please see the attached form from Dr. Gary Schuster. Thank you.

Warm regards,
Chris | Medical Receptionist

Broadway Sports & Internal Medicine
1600 116th Ave NE Suite 202
Bellevue, WA 98004
(206)215-2288 Main
(206)215-2289 fax

This e-mail, including attachments, may include confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed. If the reader of this e-mail is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this e-mail is prohibited. If you have received this e-mail in error, please notify the sender by replying to this message and delete this e-mail immediately.

FILING AUTHORIZATION FORM FOR THE FORM 5500/5500-SF

PLAN #	199397
PLAN NAME	Broadway Sports & Internal Medicine Cash Balance Plan
EIN #	n/a
PLAN YEAR ENDING	12/31/2024

Authorization of Retirement Plan Services to Electronically Sign and File

I hereby authorize Retirement Plan Services (RPS) to electronically sign and file the above named return/report through EFAST2. I understand that in granting this authority:

- ◆ I/we must manually sign and date page 1 of the Form 5500 and/or page 1 of Form 5500-SF and provide a scanned copy of that signed form to RPS before electronic filing can be initiated
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This authorization is applicable only to the filing for the above-named Plan and applies only for the Plan Year End stated above.

PLAN ADMINISTRATOR	→	GARY SCHUSTER
NAME & TITLE	→	GARY SCHUSTER MD / President
DATE	→	10-9-25
EMPLOYER/PLAN SPONSOR (ONLY FILL IN IF NOT PLAN ADMINISTRATOR)		
NAME & TITLE		
DATE		

<input checked="" type="checkbox"/> PLEASE EMAIL MY FORM 5500 TO THE EMAIL ADDRESS PROVIDED BELOW:

