

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 THE ARTHRITIS CLINIC CASH BALANCE PLAN 1b Three-digit plan number (PN) 001

1c Effective date of plan 01/01/2011

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) 2b Employer Identification Number (EIN) 59-3384750

THE ARTHRITIS CLINIC

2c Sponsor's telephone number 352-596-6333

11325 CORTEZ BLVD. BROOKSVILLE, FL 34613

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

a Sponsor's name c Plan Name

5a Total number of participants at the beginning of the plan year 6

b Total number of participants at the end of the plan year 6

c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)

c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

d(1) Total number of active participants at the beginning of the plan year 4

d(2) Total number of active participants at the end of the plan year 4

e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 0

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

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

Table with 4 columns: SIGN HERE, Signature, Date, Name. Includes entries for plan administrator and employer/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.)

| <b>Part III Financial Information</b>  |              |                              |                        |
|--|--------------|------------------------------|------------------------|
| <b>7</b> Plan Assets and Liabilities   |              | <b>(a) Beginning of Year</b> | <b>(b) End of Year</b> |
| <b>a</b> Total plan assets .....   | <b>7a</b>    | 1937444                      | 2246383                |
| <b>b</b> Total plan liabilities .....  | <b>7b</b>    | 0                            | 0                      |
| <b>c</b> Net plan assets (subtract line 7b from line 7a) .....                                       | <b>7c</b>    | 1937444                      | 2246383                |
| <b>8</b> Income, Expenses, and Transfers for this Plan Year  |              | <b>(a) Amount</b>            | <b>(b) Total</b>       |
| <b>a</b> Contributions received or receivable from:  |              |                              |                        |
| <b>(1)</b> Employers .....   | <b>8a(1)</b> | 225000                       |                        |
| <b>(2)</b> Participants .....  | <b>8a(2)</b> |                              |                        |
| <b>(3)</b> Others (including rollovers) .....  | <b>8a(3)</b> |                              |                        |
| <b>b</b> Other income (loss) .....   | <b>8b</b>    | 96516                        |                        |
| <b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....                                  | <b>8c</b>    |                              | 321516                 |
| <b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) ..... | <b>8d</b>    |                              |                        |
| <b>e</b> Certain deemed and/or corrective distributions (see instructions) .                         | <b>8e</b>    |                              |                        |
| <b>f</b> Administrative service providers (salaries, fees, commissions) .....                        | <b>8f</b>    | 12577                        |                        |
| <b>g</b> Other expenses .....  | <b>8g</b>    |                              |                        |
| <b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....   | <b>8h</b>    |                              | 12577                  |
| <b>i</b> Net income (loss) (subtract line 8h from line 8c) .....                                     | <b>8i</b>    |                              | 308939                 |
| <b>j</b> Transfers to (from) the plan (see instructions) .....                                       | <b>8j</b>    |                              |                        |

| <b>Part IV Plan Characteristics</b> |   |
|-------------------------------------|---|
| <b>9a</b>                           | If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:<br>1A 1C 3D |
| <b>b</b>                            | If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:             |

| <b>Part V Compliance Questions</b>  |            |            |           |               |
|---|------------|------------|-----------|---------------|
| <b>10</b> During the plan year:   |            | <b>Yes</b> | <b>No</b> | <b>Amount</b> |
| <b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) ..... | <b>10a</b> |            | X         |               |
| <b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....  | <b>10b</b> |            | X         |               |
| <b>c</b> Was the plan covered by a fidelity bond? .....   | <b>10c</b> | X          |           | 170000        |
| <b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....   | <b>10d</b> |            | X         |               |
| <b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....   | <b>10e</b> |            | X         |               |
| <b>f</b> Has the plan failed to provide any benefit when due under the plan? .....  | <b>10f</b> |            | X         |               |
| <b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....  | <b>10g</b> |            | X         |               |
| <b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....  | <b>10h</b> |            | X         |               |
| <b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....   | <b>10i</b> |            |           |               |

**Part VI Pension Funding Compliance**

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

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

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

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

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

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

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

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

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

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

**Part VII Plan Terminations and Transfers of Assets**

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

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

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

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

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

**Part VIII IRS Compliance Questions**

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

**14b** If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).  
 Design-based safe harbor method  
 "Prior year" ADP test  
 "Current year" ADP test  
 N/A

**15** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 08 / 31 / 2018 (MM/DD/YYYY) and the Opinion Letter serial number J501878A.

|   |  |  |
|---|--|--|
| <b>SCHEDULE SB</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Single-Employer Defined Benefit Plan</b><br><b>Actuarial Information</b><br><br>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).<br><br><b>▶ File as an attachment to Form 5500 or 5500-SF.</b> | <small>OMB No. 1210-0110</small><br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|---|--|--|

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.

|   |   |            |
|---|---|------------|
| <b>A</b> Name of plan<br><u>THE ARTHRITIS CLINIC CASH BALANCE PLAN</u>  | <b>B</b> Three-digit plan number (PN) ▶   | <u>001</u> |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF<br><u>THE ARTHRITIS CLINIC</u>                                   | <b>D</b> Employer Identification Number (EIN)<br><u>59-3384750</u>  |            |
| <b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | <b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500 |            |

|   |                            |                           |                          |
|---|----------------------------|---------------------------|--------------------------|
| <b>Part I Basic Information</b>   |                            |                           |                          |
| <b>1</b> Enter the valuation date:  | Month <u>01</u>            | Day <u>01</u>             | Year <u>2024</u>         |
| <b>2</b> Assets:  |                            |                           |                          |
| <b>a</b> Market value .....   | <b>2a</b>                  | <u>1930314</u>            |                          |
| <b>b</b> Actuarial value .....  | <b>2b</b>                  | <u>1930314</u>            |                          |
| <b>3</b> Funding target/participant count breakdown   | (1) Number of participants | (2) Vested Funding Target | (3) Total Funding Target |
| <b>a</b> For retired participants and beneficiaries receiving payment .....   | <u>0</u>                   | <u>0</u>                  | <u>0</u>                 |
| <b>b</b> For terminated vested participants .....   | <u>2</u>                   | <u>4333</u>               | <u>4333</u>              |
| <b>c</b> For active participants .....  | <u>4</u>                   | <u>2477408</u>            | <u>2479268</u>           |
| <b>d</b> Total .....  | <u>6</u>                   | <u>2481741</u>            | <u>2483601</u>           |
| <b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>   |                            |                           |                          |
| <b>a</b> Funding target disregarding prescribed at-risk assumptions .....   | <b>4a</b>                  |                           |                          |
| <b>b</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 ..... | <b>4b</b>                  |                           |                          |
| <b>5</b> Effective interest rate .....  | <b>5</b>                   | <u>4.83 %</u>             |                          |
| <b>6</b> Target normal cost   |                            |                           |                          |
| <b>a</b> Present value of current plan year accruals .....  | <b>6a</b>                  | <u>134412</u>             |                          |
| <b>b</b> Expected plan-related expenses .....   | <b>6b</b>                  | <u>11014</u>              |                          |
| <b>c</b> Target normal cost .....   | <b>6c</b>                  | <u>145426</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.

|                  |  |   |
|------------------|--|---|
| <b>SIGN HERE</b> |  |   |
|                  | Signature of actuary   | <u>09/05/2025</u><br>Date                                     |
|                  | <u>VALERIE P. LOYET, EA, ASA, MAAA</u><br>Type or print name of actuary                  | <u>23-08313</u><br>Most recent enrollment number              |
|                  | <u>NPPG, INC.</u><br>Firm name   | <u>732-758-1577</u><br>Telephone number (including area code) |
|                  | <u>494 SYCAMORE STREET<br/>SUITE 100<br/>SHREWSBURY, NJ 07702</u><br>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



|  |                        |                        |   |
|--|------------------------|------------------------|---|
| <b>Part V Assumptions Used to Determine Funding Target and Target Normal Cost</b>  |                        |                        |   |
| <b>21</b> Discount rate:   |                        |                        |   |
| <b>a</b> Segment rates:  | 1st segment:<br>4.75 % | 2nd segment:<br>4.96 % | <input type="checkbox"/> N/A, full yield curve used |
| <b>b</b> Applicable month (enter code) .....   |                        |                        | <b>21b</b> 0  |
| <b>22</b> Weighted average retirement age .....  |                        |                        | <b>22</b> 62  |
| <b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute |                        |                        |   |

|   |  |  |           |
|---|--|--|-----------|
| <b>Part VI Miscellaneous Items</b>  |  |  |           |
| <b>24</b> 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 |  |  |           |
| <b>25</b> 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                                      |  |  |           |
| <b>26</b> Demographic and benefit information   |  |  |           |
| <b>a</b> 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>b</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                       |  |  |           |
| <b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....   |  |  | <b>27</b> |

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

|  |                     |                    |                   |
|--|---------------------|--------------------|-------------------|
| <b>Part VIII Minimum Required Contribution For Current Year</b>  |                     |                    |                   |
| <b>31</b> Target normal cost and excess assets (see instructions):   |                     |                    |                   |
| <b>a</b> Target normal cost (line 6c) .....  |                     |                    | <b>31a</b> 145426 |
| <b>b</b> Excess assets, if applicable, but not greater than line 31a .....   |                     |                    | <b>31b</b> 0      |
| <b>32</b> Amortization installments:   | Outstanding Balance | Installment        |                   |
| <b>a</b> Net shortfall amortization installment .....  | 553785              | 53504              |                   |
| <b>b</b> Waiver amortization installment.....  |                     |                    |                   |
| <b>33</b> 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 ..... |                     |                    | <b>33</b>         |
| <b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....  |                     |                    | <b>34</b> 198930  |
|  | Carryover balance   | Prefunding balance | Total balance     |
| <b>35</b> Balances elected for use to offset funding requirement .....   |                     |                    | 0                 |
| <b>36</b> Additional cash requirement (line 34 minus line 35) .....  |                     |                    | <b>36</b> 198930  |
| <b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....  |                     |                    | <b>37</b> 200310  |
| <b>38</b> Present value of excess contributions for current year (see instructions)  |                     |                    |                   |
| <b>a</b> Total (excess, if any, of line 37 over line 36)   |                     |                    | <b>38a</b> 1380   |
| <b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances.....   |                     |                    | <b>38b</b> 0      |
| <b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....  |                     |                    | <b>39</b> 0       |
| <b>40</b> Unpaid minimum required contributions for all years .....  |                     |                    | <b>40</b> 0       |

|   |  |  |  |
|---|--|--|--|
| <b>Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)</b>   |  |  |  |
| <b>41</b> 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, line 19 - Discounted Employer Contributions**

**Plan Name: The Arthritis Clinic Cash Balance Plan**

**Plan Sponsor's Name: The Arthritis Clinic**

**Plan Sponsor's EIN: 59-3384750**

**Plan Number: 001**

**Interest Rates for Contribution Year End Date: 12/31/2024**

**Effective: 4.83%**

**Late Quarterly: 9.83%**

| <u>Effective Date</u> | <u>Amount</u>    | <u>Effective Interest</u> | <u>Quarterly Interest</u> | <u>Discounted</u> |
|-----------------------|------------------|---------------------------|---------------------------|-------------------|
| 09/04/2025            | \$225,000        | -17,083                   | -7,607                    | \$200,310         |
|                       | <u>\$225,000</u> |                           |                           | <u>\$200,310</u>  |

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

**Plan Name: The Arthritis Clinic Cash Balance Plan**

**Plan Sponsor's Name: The Arthritis Clinic**

**Plan Sponsor's EIN: 59-3384750**

**Plan Number: 001**

The weighted average retirement age 62 of is the average of the assumed retirement ages for all active participants as of the valuation date rounded to the nearest whole age. For an active late retiree, the assumed retirement age may be later than the Plan's normal retirement age. Each participant's rate of retirement is assumed to be 100% of his/her assumed retirement age.

**Schedule SB, Part V - Statement of Actuarial Assumptions**

**Plan Name: The Arthritis Clinic Cash Balance Plan**

**Plan Sponsor's Name: The Arthritis Clinic**

**Plan Sponsor's EIN: 59-3384750**

**Plan Number: 001**

**Target Assumptions:**

**Male Nonannuitant:** 2024 Nonannuitant Male  
**Female Nonannuitant:** 2024 Nonannuitant Female  
**Male Annuitant:** 2024 Annuitant Male  
**Female Annuitant:** 2024 Annuitant Female  
**Male Optional:** 2024 Optional table small plans Male  
**Female Optional:** 2024 Optional table small plans Female

**Options:**

**Use optional combined mortality table for small plans:** Yes  
**Use discount rate transition:** No  
**Lump sums use:** Final regulations (IRS & FASB)  
**Probability of lump sum:** 100.00%  
**Use pre-retirement mortality:** No  
**Shortfall amortization:** 7 year  
**At-risk calculations:** System calculations

**Funding:**

**Applicable months from valuation month:** 0

|                               | <u>1st</u> | <u>2nd</u> | <u>3rd</u> |
|-------------------------------|------------|------------|------------|
| <b>Segment rates:</b>         | 4.37       | 4.96       | 4.95       |
| <b>25 year average rates:</b> | 3.33       | 5.13       | 5.88       |
| <b>Final rates:</b>           | 4.75       | 4.96       | 5.59       |
| <b>Override:</b>              | 0.00       | 0.00       | 0.00       |

**Actuarial Equivalent Floor**

**Lookback months:** 1  
**Stability period:** plan year  
**Nonannuitant:** N/A  
**Annuitant:** 2024 Applicable

|                  | <u>1st</u> | <u>2nd</u> | <u>3rd</u> |
|------------------|------------|------------|------------|
| <b>Current:</b>  | 5.01       | 5.13       | 5.15       |
| <b>Override:</b> | 0.00       | 0.00       | 0.00       |

**Retirement Actuarial Equivalent Assumptions**

|                 |                                |                                 |
|-----------------|--------------------------------|---------------------------------|
| <b>Interest</b> | <b>Pre-retirement</b><br>5.00% | <b>Post-retirement</b><br>5.50% |
|-----------------|--------------------------------|---------------------------------|

**Mortality & Setbacks**

|        |          |                      |
|--------|----------|----------------------|
| Male   | N/A None | 2024 Applicable None |
| Female | N/A None | 2024 Applicable None |

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

**Plan Name: The Arthritis Clinic Cash Balance Plan**

**Plan Sponsor's Name: The Arthritis Clinic**

**Plan Sponsor's EIN: 59-3384750**

**Plan Number: 001**

**Employer and Plan Data**

|                        |            |
|------------------------|------------|
| Initial effective date | 01/01/2011 |
| Plan year begins       | 01/01/2024 |
| Plan year ends         | 12/31/2024 |
| Valuation date         | 01/01/2024 |

**Eligibility Requirements**

|                      |    |
|----------------------|----|
| Waiting period (mos) | 12 |
| Minimum age          | 21 |
| Minimum age (mos)    | 0  |

**Normal Retirement**

|                                |                        |
|--------------------------------|------------------------|
| Minimum age                    | 62                     |
| Minimum years of service       | 0                      |
| Minimum years of participation | 5                      |
| Retirement date                | 1st of month following |

**Vesting** 3 Year Cliff

**Cash Balance Criteria**

| <u>Allocation Class</u> | <u>Default</u> | <u>Allocation Formula</u> |
|-------------------------|----------------|---------------------------|
| A                       |                | 58.00%                    |
| B                       |                | 2.50%                     |
| C                       | X              | 1.50%                     |

**Interest Credit** 5.50%

Schedule SB, line 32 - Schedule of Amortization Bases

Plan Name: The Arthritis Clinic Cash Balance Plan

Plan Sponsor's Name: The Arthritis Clinic

Plan Sponsor's EIN: 59-3384750

Plan Number: 001

Charges/Credits

| <u>Type of Base</u> | <u>Effective Date</u> | <u>Interest Rate</u> | <u>Initial Amount</u> | <u>Initial Amort</u> | <u>Current Balance</u> | <u>Rem Amort</u> | <u>Payment</u> |
|---------------------|-----------------------|----------------------|-----------------------|----------------------|------------------------|------------------|----------------|
| Shortfall           | 01/01/2022            | 4.75 / 4.96          | 37,500                | 15.00                | 34,306                 | 13.00            | 3,465          |
| Shortfall           | 01/01/2023            | 4.75 / 4.96          | 602,519               | 15.00                | 575,717                | 14.00            | 55,179         |
| Shortfall           | 01/01/2024            | 4.75 / 4.96          | -56,238               | 15.00                | -56,238                | 15.00            | -5,140         |
| <b>Totals</b>       | Shortfall             |                      |                       |                      | 553,785                |                  | 53,504         |

|   |  |  |
|---|--|--|
| <b>SCHEDULE SB</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Single-Employer Defined Benefit Plan</b><br><b>Actuarial Information</b><br><br>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).<br><br><b>▶ File as an attachment to Form 5500 or 5500-SF.</b> | <small>OMB No. 1210-0110</small><br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|---|--|--|

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.

|   |   |     |
|---|---|-----|
| <b>A</b> Name of plan<br>The Arthritis Clinic Cash Balance Plan   | <b>B</b> Three-digit plan number (PN) ▶   | 001 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF<br>The Arthritis Clinic  | <b>D</b> Employer Identification Number (EIN)<br><br>59-3384750   |     |
| <b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | <b>F</b> 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**

|          |   |                            |                           |
|----------|---|----------------------------|---------------------------|
| <b>1</b> | Enter the valuation date: Month <u>1</u> Day <u>1</u> Year <u>2024</u>  |                            |                           |
| <b>2</b> | Assets:   |                            |                           |
|          | <b>a</b> Market value .....   | <b>2a</b>                  | 1,930,314                 |
|          | <b>b</b> Actuarial value .....  | <b>2b</b>                  | 1,930,314                 |
| <b>3</b> | Funding target/participant count breakdown  | (1) Number of participants | (2) Vested Funding Target |
|          | <b>a</b> For retired participants and beneficiaries receiving payment .....   | 0                          | 0                         |
|          | <b>b</b> For terminated vested participants .....   | 2                          | 4,333                     |
|          | <b>c</b> For active participants .....  | 4                          | 2,477,408                 |
|          | <b>d</b> Total .....  | 6                          | 2,481,741                 |
| <b>4</b> | If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>  |                            |                           |
|          | <b>a</b> Funding target disregarding prescribed at-risk assumptions .....   | <b>4a</b>                  |                           |
|          | <b>b</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 ..... | <b>4b</b>                  |                           |
| <b>5</b> | Effective interest rate .....   | <b>5</b>                   | 4.83 %                    |
| <b>6</b> | Target normal cost .....  |                            |                           |
|          | <b>a</b> Present value of current plan year accruals .....  | <b>6a</b>                  | 134,412                   |
|          | <b>b</b> Expected plan-related expenses .....   | <b>6b</b>                  | 11,014                    |
|          | <b>c</b> Target normal cost .....   | <b>6c</b>                  | 145,426                   |

**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.

|                  |   |   |
|------------------|---|---|
| <b>SIGN HERE</b> | <br>Signature of actuary | <u>09/05/2025</u><br>Date                                       |
|                  | Valerie P. Loyet, EA, ASA, MAAA<br>Type or print name of actuary  | <u>23-08313</u><br>Most recent enrollment number                |
|                  | NPPG, Inc.<br>Firm name   | <u>(732) 758-1577</u><br>Telephone number (including area code) |
|                  | 494 Sycamore Street<br>Suite 100<br>Shrewsbury NJ 07702<br>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



|   |                                       |   |  |                                     |
|---|---------------------------------------|---|--|-------------------------------------|
| <b>Part V Assumptions Used to Determine Funding Target and Target Normal Cost</b> |                                       |   |  |                                     |
| <b>21</b>   | Discount rate:                        |   |  |                                     |
| <b>a</b>  | Segment rates:                        | 1st segment:<br>4.75 %                                    | 2nd segment:<br>4.96 %                         | 3rd segment:<br>5.59 %              |
|   |                                       | <input type="checkbox"/> N/A, full yield curve used       |  |                                     |
| <b>b</b>  | Applicable month (enter code) .....   | <b>21b</b>  | 0  |                                     |
| <b>22</b>   | Weighted average retirement age ..... | <b>22</b>   | 62   |                                     |
| <b>23</b>   | Mortality table(s) (see instructions) | <input checked="" type="checkbox"/> Prescribed - combined | <input type="checkbox"/> Prescribed - separate | <input type="checkbox"/> Substitute |

|                                    |   |           |  |   |
|------------------------------------|---|-----------|--|---|
| <b>Part VI Miscellaneous Items</b> |   |           |  |   |
| <b>24</b>                          | 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 |           |  |   |
| <b>25</b>                          | 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                                      |           |  |   |
| <b>26</b>                          | Demographic and benefit information   |           |  |   |
| <b>a</b>                           | 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>b</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 |
| <b>27</b>                          | If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....   | <b>27</b> |  |   |

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

|   |  |                     |                    |               |
|---|--|---------------------|--------------------|---------------|
| <b>Part VIII Minimum Required Contribution For Current Year</b> |  |                     |                    |               |
| <b>31</b>   | Target normal cost and excess assets (see instructions):   |                     |                    |               |
| <b>a</b>  | Target normal cost (line 6c) .....   | <b>31a</b>          | 145,426            |               |
| <b>b</b>  | Excess assets, if applicable, but not greater than line 31a .....  | <b>31b</b>          | 0                  |               |
| <b>32</b>   | Amortization installments:   | Outstanding Balance | Installment        |               |
| <b>a</b>  | Net shortfall amortization installment .....   | 553,785             | 53,504             |               |
| <b>b</b>  | Waiver amortization installment .....  |                     |                    |               |
| <b>33</b>   | 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 ..... | <b>33</b>           |                    |               |
| <b>34</b>   | Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....  | <b>34</b>           | 198,930            |               |
| <b>35</b>   | Balances elected for use to offset funding requirement .....   | Carryover balance   | Prefunding balance | Total balance |
|   |  |                     |                    | 0             |
| <b>36</b>   | Additional cash requirement (line 34 minus line 35) .....  | <b>36</b>           | 198,930            |               |
| <b>37</b>   | Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....  | <b>37</b>           | 200,310            |               |
| <b>38</b>   | Present value of excess contributions for current year (see instructions)  |                     |                    |               |
| <b>a</b>  | Total (excess, if any, of line 37 over line 36)  | <b>38a</b>          | 1,380              |               |
| <b>b</b>  | Portion included in line 38a attributable to use of prefunding and funding standard carryover balances.....  | <b>38b</b>          | 0                  |               |
| <b>39</b>   | Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....  | <b>39</b>           | 0                  |               |
| <b>40</b>   | Unpaid minimum required contributions for all years .....  | <b>40</b>           | 0                  |               |

|   |   |  |  |  |
|---|---|--|--|--|
| <b>Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)</b> |   |  |  |  |
| <b>41</b>   | 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 |  |  |  |

**Form 5500-SF**

**Short Form Annual Return/Report of Small Employer  
Benefit Plan**

OMB Nos. 1510-0118  
1510-0089

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employer Benefits Security Administration  
Pension Benefit Guaranty Corporation

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 of the Internal Revenue Code (the Code).

2024

This Form is Open to Public Inspection

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

**Part I Annual Report Identification Information**

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

**A** This return/report is for:  a single-employer plan  a multiple employer plan (multiple employer plan filers filing this report must attach Schedule MEP. Multiple employer filers 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  DFV 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  
The Arthritis Clinic Cash Balance Plan

**1b** Three digit plan number (PN) 001

**1c** Effective date of plan  
01/01/2011

**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)  
The Arthritis Clinic  
11325 Cortez Blvd.  
Brooksville FL 34613

**2b** Employer identification number (EIN)  
59-894750

**2c** Sponsor's telephone number  
(352) 596-6333

**2d** Business code (see instructions)  
621111

**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.

**a** Sponsor's name

**c** Plan Name

|  |   |   |
|--|---|---|
| <b>5a</b> Total number of participants at the beginning of the plan year   | 5 | 6 |
| <b>b</b> Total number of participants at the end of the plan year  | 5 | 6 |
| <b>c(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | 5 |   |
| <b>c(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)       | 5 |   |
| <b>d(1)</b> Total number of active participants at the beginning of the plan year  | 5 | 4 |
| <b>d(2)</b> Total number of active participants at the end of the plan year  | 5 | 4 |
| <b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested               | 0 | 0 |

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless the plan can be established as being qualified under the Code.** Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including any attachments, and signed it as required by the instructions, as well as the electronic version of this return/report, to the best of my knowledge and belief, it is true, correct, and complete.

|                  |                     |          |              |                       |
|------------------|---------------------|----------|--------------|-----------------------|
| <b>SIGN HERE</b> | <i>Anas Mouraid</i> | 10-15-25 | Anas Mouraid | Employer/Plan Sponsor |
| <b>SIGN HERE</b> |                     |          | Anas Mouraid | Employer/Plan Sponsor |

EFAST2 Filing Authorization Form  
For Form 5500-SF

Name of Plan: The Arthritis Clinic Cash Balance Plan

EIN / PN: 59-3384750 / 001

Plan Year Ending: 12/31/2024

**Authorization of Practitioner to Electronically Sign and File**

I hereby authorize National Professional Planning Group, Inc. ("NPPG") to electronically sign and file the above-named return/report through EFAST2.

I understand that in granting this authority that:

- I must manually sign and date Page 1 of the Form 5500-SF and provide a copy of that signature page to NPPG before the electronic filing can be initiated;
- NPPG will retain a copy of this written authorization in its records;
- NPPG will notify the individual signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS, or PBO regarding this annual return/report; and
- NPPG shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.

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: Anas Mowaiden Date: 10-15-25  
[Signature] Date: 10-15-25

The designated service provider must retain this authorization.  
Do not submit this form to the DOL, unless required to do so.