

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans 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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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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 multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

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 If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

<p>1a Name of plan <u>THE DENTISTS' GUILD RETIREMENT PROGRAM PEP</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>016</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>THE FINWAY GROUP</u></p> <p><u>5625 MILLS CIVIC PARKWAY</u> <u>SUITE 101</u> <u>WEST DES MOINES, IA 50266</u></p>	<p>1c Effective date of plan <u>05/01/2023</u></p> <p>2b Employer Identification Number (EIN) <u>42-1468222</u></p> <p>2c Plan Sponsor's telephone number <u>515-226-0974</u></p> <p>2d Business code (see instructions) <u>621210</u></p>

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 accompanying schedules, statements and attachments, 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.	10/15/2025	STEVE FINNEGAN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	STEVE FINNEGAN
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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	
5 Total number of participants at the beginning of the plan year	5	0
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	0
	6a(2)	583
	6b	14
	6c	93
	6d	690
	6e	0
	6f	690
	6g(1)	0
6g(2)	577	
6h	23	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
 2A 2E 2J 2K 2F 2G 2W

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules	b General Schedules
(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)	(1) <input type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input checked="" type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input type="checkbox"/> A (Insurance Information) – Number Attached <u>0</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input type="checkbox"/> C (Service Provider Information)
(5) <input checked="" type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE I (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>	Financial Information—Small Plan This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<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**

A Name of plan THE DENTISTS' GUILD RETIREMENT PROGRAM PEP	B Three-digit plan number (PN) ▶ 016
C Plan sponsor's name as shown on line 2a of Form 5500 THE FINWAY GROUP	D Employer Identification Number (EIN) 42-1468222

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

		(a) Beginning of Year	(b) End of Year
1 Plan Assets and Liabilities:			
a Total plan assets	1a	0	132196379
b Total plan liabilities	1b	0	
c Net plan assets (subtract line 1b from line 1a)	1c	0	132196379
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable:			
(1) Employers	2a(1)	3198848	
(2) Participants	2a(2)	3804966	
(3) Others (including rollovers)	2a(3)	0	
b Noncash contributions	2b	0	14988694
c Other income	2c	7984880	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		
e Benefits paid (including direct rollovers)	2e	3634854	
f Corrective distributions (see instructions)	2f	0	3904736
g Certain deemed distributions of participant loans (see instructions)	2g	0	
h Administrative service providers (salaries, fees, and commissions)	2h	269882	
i Other expenses	2i		11083958
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		
k Net income (loss) (subtract line 2j from line 2d)	2k		121112421
l Transfers to (from) the plan (see instructions)	2l		

3 Specific Assets: If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	
c Real estate (other than employer real property)	3c		X	
d Employer securities	3d		X	
e Participant loans	3e	X		13738
f Loans (other than to participants)	3f		X	
g Tangible personal property	3g		X	

Part II	Compliance Questions
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		Yes	No	Amount
4 During the plan year:				
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.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b 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.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

SCHEDULE R (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>	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 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**

A Name of plan THE DENTISTS' GUILD RETIREMENT PROGRAM PEP	B Three-digit plan number (PN) ▶	016
C Plan sponsor's name as shown on line 2a of Form 5500 THE FINWAY GROUP	D Employer Identification Number (EIN) 42-1468222	

Part I	Distributions
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All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	0
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2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
EIN(s): _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	
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Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)
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4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 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 ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

Part III	Amendments
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9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... Increase Decrease Both No

Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
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10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment).....	14a	
b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14b	
c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14c	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....	16b	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
 Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%
 High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No

b If line 20a is "Yes," 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: _____

Part VII IRS Compliance Questions

21a 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

21b 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

22 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 Q704094A.

<p style="text-align: center;">SCHEDULE MEP (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p>	<p style="font-size: large;">MULTIPLE-EMPLOYER RETIREMENT PLAN INFORMATION</p> <p style="font-size: small;">This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and Section 6058(a) of the Internal Revenue Code (the Code)</p> <p style="text-align: center;">▶ File as an attachment to Form 5500.</p>	<p style="text-align: right; font-size: small;">OMB No. 1210-0110</p> <hr/> <p style="text-align: center; font-size: large;">2024</p> <hr/> <p style="text-align: center; font-size: small;">This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<p>A Name of plan THE DENTISTS' GUILD RETIREMENT PROGRAM PEP</p>	<p>B Three-digit Plan number (PN)..... ▶</p>	<p>016</p>
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<p>C Plan administrator's name as shown on line 3a of Form 5500/Form 5500-SF THE FINWAY GROUP</p>	<p>D Administrator's EIN 42-1468222</p>
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Part I Type of Multiple-Employer Pension Plan. All multiple-employer pension plans must complete.

1 Check the appropriate box to indicate type of multiple-employer pension plan. (Only defined contribution plans may check lines 1a, 1b, and 1c. Defined benefit plans and defined contribution plans not checking lines 1a, 1b, or 1c should check line 1d. See Instructions).

- a association retirement plan (See 29 CFR 2510.3-55) (Complete Part II)
- b professional employer organization plan (PEO Plan) (See 29 CFR 29 CFR 2510.3-55) (Complete Part II)
- c pooled employer plan (PEP) (See 29 CFR 2510.3-44) (Complete Parts II and III)
- d other multiple-employer pension plan (Describe) _____ (Complete Part II)

Part II Participating Employer Information.

2 All multiple-employer pension plans that are subject to section 210(a) of ERISA (see instructions for filing the Form 5500) must complete Part II, in addition to Part I, in accordance with the instructions, to report the information for each employer participating in the multiple-employer pension plan. **Defined contribution plans must complete lines 2a-2d. All other multiple-employer pension plans complete lines 2a-2c only. Complete as many entries as needed to list the required information for each participating employer that is not an individual person (see instructions).**

2a Name of Participating Employer A PINEDA SO, DDS, INC.	2b EIN 33-1090532	2c Percentage of Total Contributions for the Plan Year 1.35	2d Aggregate Account Balances Attributable to Participating Employer 1789915
2a Name of Participating Employer ACOSTA DENTAL PRACTICE, PC	2b EIN 45-4176478	2c Percentage of Total Contributions for the Plan Year 0.85	2d Aggregate Account Balances Attributable to Participating Employer 1121891

CAUTION Do not individually list information for working owners (see instructions and 29 CFR 2510.3-55(d)(2)) or other individuals who are participants or beneficiaries in the plan or arrangement that are no longer associated with a particular participating employer or participating employer plan (see instructions). Providing identifying information for individuals may result in rejection of this filing. If there are any such individuals in the plan, answer "Yes" to line 2e and provide the total information for all such individuals, without providing names or other identifying information.

2e Does the plan include any individuals not participating through an employer or who are individual working owners?	2e	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2f If you answer "Yes" in line 2e, enter a good faith estimate of the percentage of total contributions made by all such individuals that are not listed on line 2a during the plan year.	2f	
2g If you answer "Yes" in Line 2e, enter the aggregate account balances for all such individuals that are not listed on line 2a.	2g	

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

**Schedule MEP (2024)
v. 240311**

Part II Participating Employer Information (Continued).

Use this page for additional participating employer information.

2 All multiple-employer pension plans that are subject to section 210(a) of ERISA (see instructions for filing the Form 5500) must complete Part II, in addition to Part I, in accordance with the instructions, to report the information for each employer participating in the multiple-employer pension plan.

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2a Name of Participating Employer	2b EIN	2c Percentage of Total Contributions for the Plan Year	2d Aggregate Account Balances Attributable to Participating Employer
AGATA KONOPKA, DDS, A DENTAL CORPORATION	47-2742615	0.08	99597
ALAMEDA PERIODONTICS	47-5569626	0.31	411014
ANDREW KOMASHKO, DDS	77-0579728	1.21	1607204
ANN M. DONNELLY, DDS, INC.	46-3024159	0.57	751341
ANNA K. TALMOOD, DDS, INC.	33-0783903	0.40	536860
ARASH M. ZADEH, DDS, INC.	36-4603701	0.10	134583
ARIANE R. TERLET, DDS	94-3123339	0.92	1225748
BALFOUR J. KAY, DDS	94-3111919	0.52	690550
BASHAR AZAR, DDS, INC	81-0987491	0.13	176793

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Part II Participating Employer Information (Continued).

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BRADLEY C. LOUIE, D.D.S., INC.	68-0371155	2.14	2836158
BRIAN B. FONG DMD, MD	83-1795116	0.87	1149430
BRIAN P. KAIL, DDS	05-0594460	0.27	363212
BRIAN T. TANAKA, DMD	33-0952226	0.09	121357
CALIFORNIA DENTISTS' GUILD	94-6130330	0.09	121987
CARRIE S. NISHIMOTO, DDS	77-0581048	0.33	439810
CHRISTINA CHEN, DDS, INC.	93-2522210	0.02	23143
CORY C. STACPOOLE, D.D.S.	94-2912824	0.09	121869
DAI H. BUI, DDS, INC.	46-2403095	0.20	261492

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DAMON J. WESTWOOD, D.D.S., INC.	90-0943053	1.52	2011882
DANIEL CHENG DDS	95-4838593	0.00	0
DANIEL H. TAMURA, DDS	55-0797755	0.19	247875
DAVID S. KEEN, D.D.S., M.S.	65-1245160	1.46	1944859
DAVID T. CHEUNG, DDS, PC	33-0962427	1.18	1560855
DENTISTCA, DENTAL PRACTICE OF JOHN K. LEUNG, DDS PC	81-3137598	0.31	412958
DONNA ARASE, DDS	95-4605573	0.41	545661
DOUGLAS A. GEDESTAD, DMD, INC.	91-1824987	0.20	267999
DOUGLAS SAKURAI, DDS	33-0388175	0.88	1167866

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DR. MICHAEL FLEMING DENTAL CORPORATION	84-3537085	0.11	151383
DRS. CHENG AND ROITMAN	36-4710705	0.69	914936
EDITHANN J. GRAHAM, DMD, MS, INC.	26-3302642	1.66	2204067
ELLEN PACLEB, DDS	68-0453565	1.62	2149723
ERIC B. DIXON DDS MSD	91-2071489	2.56	3404199
EXCEL GENERAL AND COSMETIC DENTISTRY	20-4208025	1.25	1663049
FLAVIO CHENG, DDS, A PROFESSIONAL CORPORATION	86-2191056	0.86	1147073
FOLASHADE BARMIDELE-AKINYEMI DMD INC.	26-2380668	0.86	1136566
FRANCINE KITAGAWA, D.D.S., APC	82-4194789	0.47	628815

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FRANK CHEN, DDS AND JUDY SU, DDS, A PROFESSIONAL CORPORATION	94-3399981	3.21	4264225
GEORGE A. SORIANO, DMD, INC.	94-3358233	1.98	2624411
GILBERT B. LAM, DDS, INC.	27-3699988	1.41	1876945
GREGORY & DEBORAH OWYANG DDS	27-1771635	2.37	3144185
H. THAO TRAN, DDS	45-5396572	0.34	453403
HA NGUYEN LEE, DDS, INC. A PROFESSIONAL CORPORATION	47-5155851	0.26	341325
HENSPETTER AND JEN KIN DENTAL PARTNERSHIP	81-0934617	1.46	1938010
HOANG T. TRAN, DDS, INC.	20-0443977	2.08	2767472
HUAYANG JOHN WU, DDS INC.	47-2731828	1.02	1356442

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HUNG LU, DDS, INC.	26-4541149	0.83	1099078
J. BRENT GORRELL	94-2765561	0.40	530734
JACK YU, DDS	20-5656484	0.52	686043
JAMES C. MA DDS, INCORPORATED	39-2066646	1.22	1613243
JAMES W. CHILDRESS, DDS INC.	94-2915080	3.12	4135507
JASNA GALEB, DDS	59-3823895	0.89	1185646
JOANNE KARLA GABOT-HEYMAN DDS, INC	47-4965154	0.07	96161
JOHN C. BIRCH, DDS	68-0484810	0.82	1088748
JOHN MOON, DDS, INC.	84-1664042	1.07	1416227

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JOSH BARKHORDAR, DDS	81-2596316	0.09	114893
JUSTIN CHAPMAN, D.D.S.	41-2120073	0.87	1158947
KAINOS DENTAL TECHNOLOGIES, LLC	45-2883735	0.21	279915
KAMYAR NEGARI, DDS, INC.	27-4480844	0.65	860239
KARKHANECHI D.D.S., INC.	83-2262194	0.15	197065
KAWATA DENTAL, INC.	95-4888484	0.45	601641
KEVIN C. LIN, DDS	82-0938259	0.61	812322
KEVIN J. COOLIDGE, DDS	83-1094960	1.13	1498673
KEVIN LOW, DDS	56-2458557	3.22	4273544

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LISA J. DOBAK, DDS	68-0247492	0.97	1292545
LOUIS B. DANG, DDS	47-2160174	1.18	1562061
LOWELL B. DAVIS, D.D.S., M.S	94-2398452	0.19	253542
MARIA A. CANUTO, DDS INC.	54-2184060	0.20	264754
MARIE MALLORY DDS	26-1263769	1.00	1332295
MARK T. NII, DDS	94-3269121	0.65	869469
MARTIN HOFF MD DDS	94-3248110	1.50	1986738
MARY M CHIEN DDS MS INC	95-4850890	0.79	1048665
MATTHEW A. KORN DDS PROFESSIONAL CORPORATION	81-4797544	1.82	2412515

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MATTHEW LAU, DDS INC.	47-2398080	0.22	291474
MELVIN COHEN, DDS	85-1155108	0.30	401313
MICHAEL A. LEE, DDS	95-4875410	0.48	633245
MICHAEL MONTGOMERY DDS	95-3693647	0.19	256575
MICHAEL PARRETT, DDS	94-2913989	0.00	0
MICHAEL S. YUNG DDS, INC	46-0541732	0.67	886366
MICHEL RAAD, DDS, PC	87-1111002	0.17	220969
MIKE TRAN, DDS, A PROFESSIONAL DENTAL CORPORATION	27-1567034	1.27	1690712
MINAL J. PATEL, DMD, INC.	46-4292759	0.74	987547

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MORIS AYNECHI, DDM, MD APC	20-8228653	0.20	264793
NATHAN M. VOGT, DDS	20-5366510	1.02	1352541
NICOLE BARKHORDAR DDS M.ED, INC.	81-5119599	0.07	89325
NORTHRIDGE DENTAL GROUP	95-4851964	0.31	410873
PATRICIA J. DRILLING DDS	77-0496908	1.44	1917671
PETER T. SU, DDS A PROFESSIONAL CORPORATION	71-0940390	0.87	1151709
PETER YOUNG, DDS, INC.	95-4588528	1.96	2607866
QUYNH NGO DMD, INC.	47-3031612	0.09	116494
RAFI BALABANIAN, DDS, MAGD	77-0325077	0.54	713738

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RAHMAT BARKHORDAR, DDS	76-0719363	0.05	65550
RAJU REDDY, DDS, MD, INC.	42-1678265	0.94	1250385
RANDY FONG, D.D.S.	33-0261869	0.17	224898
RAYNATO CASTRO, DDS, INC.	47-4330062	0.63	830096
REBECCA ARMEL, D.D.S., INC	20-4740972	0.06	83989
RICH HIRSCHINGER, DDS, INC.	46-1094931	0.26	346020
ROLAND G. CHEW, DDS	27-0707410	0.45	595902
S. SHAUN DANESHGAR, DMD	88-1443534	0.22	293342
SADIE MESTMAN DDS	95-4117512	1.88	2489559

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SALIM ANDRES ABUSLEME, DDS INC.	94-3407582	1.09	1440709
SHAH AND KARIA DENTAL CORPORATION	47-3137757	0.45	599464
STEVEN H. YOSHIOKA, DDS	77-0108576	2.19	2913284
STEVEN MERCHANT, DDS A DENTAL CORPORATION	46-5709988	1.09	1449978
SUSHMITA BHARDWAJ, DDS CORPORATION	47-1151754	0.33	433761
TAMLYN S. LEE, DDS INC.	54-2185925	0.28	369674
THOMAS LEQUIA, DDS	77-0355654	2.04	2703408
TIFFANY LEE, DDS	33-0562606	1.44	1912846
TIMOTHY M PENTECOST DDS A PROFESSIONAL CORPORATION	20-5025870	1.06	1409763

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TRAN VILLAS DENTAL, PC	46-1499623	1.12	1484543
WAH K. MARK, DDS	68-0374677	4.02	5341594
WALDEMAR CHMIELEWSKI, DDS	95-4407621	0.31	413299
WILSON W. LEUNG, D.D.S.	94-2963081	2.20	2925986
WOLFGANG BOECK, DDS	27-1576720	0.48	632649
YUAN TAO, DMD PROFESSIONAL CORPORATION	46-2855115	0.57	751094
YUHAO GAO A PROFESSIONAL CORPORATION	45-4846921	0.56	746998
YUNFEI FAN DDS APC	45-4862395	0.05	71742

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Part III	Pooled Employer Plan Information
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Line 3. All Pooled employer plans must answer all of the questions in Part III, in addition to completing all of Parts I and II.

3a Is the pooled plan provider (identified as the plan sponsor and administrator in Part II of the Form 5500) currently in compliance with the Form PR (Pooled Plan Provider Registration Statement) requirements? (See instructions and 29 CFR 2510.3-44)..... Yes No

3b If line 3a is "Yes", enter the ACK ID for the most recent Form PR that was required to be filed under the Form PR filing requirements. (Failure to enter a valid ACK ID will subject the Form 5500 filing to rejection as incomplete.)

ACK ID R47U9GXIB

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Department of the Treasury Internal Revenue Service

This form is required to be filed for employee benefit plans 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).

2024

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation

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 multiemployer plan [X] a multiple-employer plan... B This return/report is: [X] the first return/report... C If the plan is a collectively-bargained plan, check here... D Check box if filing under: [X] Form 5558... 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 Dentists' Guild Retirement Program PEP
1b Three-digit plan number (PN): 016
1c Effective date of plan: 05/01/2023
2a Plan sponsor's name (employer, if for a single-employer plan): The Finway Group
2b Employer Identification Number (EIN): 42-1468222
2c Plan Sponsor's telephone number: 515-226-0974
2d Business code (see instructions): 621210

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 accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Contains two rows for Steve Finnegan, one as plan administrator and one as employer/plan sponsor, both dated 10/15/25.

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____
