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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 02/01/2023 and ending 01/31/2024

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: [ ] Form 5558 [ ] automatic extension [X] 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
GERALD C. BERKMAN, M.D., A MEDICAL CORP. PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 02/01/1988

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)
GERALD C. BERKMAN, M.D., A MEDICAL CORP.

32144 W AGOURA ROAD, SUITE 211
WESTLAKE VILLAGE, CA 91361

2b Employer Identification Number (EIN) 95-3537304

2c Sponsor's telephone number 818-889-8387

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.
a Sponsor's name
c Plan Name

4b EIN

4d PN

5a Total number of participants at the beginning of the plan year	**5a**	4
b Total number of participants at the end of the plan year	**5b**	4
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**5c(1)**	3
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**5c(2)**	3
d(1) Total number of active participants at the beginning of the plan year	**5d(1)**	3
d(2) Total number of active participants at the end of the plan year	**5d(2)**	3
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**5e**	0

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/22/2025	GERALD BERKMAN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] 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.) [X] Yes [ ] No

If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? [ ] Yes [ ] No [ ] Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year_____. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	55597	33145
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	55597	33145
8 Income, Expenses, and Transfers for this Plan Year		**(a) Amount**	**(b) Total**
a Contributions received or receivable from: (1) Employers	8a(1)		
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	2338	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		2338
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	24700	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	90	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		24790
i Net income (loss) (subtract line 8h from line 8c)	8i		-22452
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 3D

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

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		100000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

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

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

b **PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than $0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation _____

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

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

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

b Enter the minimum required contribution for this plan year	**12b**	
c Enter the amount contributed by the employer to the plan for this plan year	**12c**	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	**12d**	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?		☐ Yes ☐ No ☐ N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?		☐ Yes ☒ No
a If "Yes," enter the amount of any plan assets that reverted to the employer this year	**13a**	
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☐ Yes ☒ No

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

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

Part VIII IRS Compliance Questions

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

14b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- ☐ Design-based safe harbor method
- ☐ "Prior year" ADP test
- ☐ "Current year" ADP test
- ☒ N/A

15 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q703912A.

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 section 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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 02/01/2023 and ending 01/31/2024

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: [ ] Form 5558 [ ] automatic extension [X] 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
Gerald C. Berkman, M.D., A Medical Corp. Profit Sharing Plan

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 02/01/1988

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)
Gerald C. Berkman, M.D., A Medical Corp.

32144 W Agoura Road, Suite 211

US Westlake Village CA 91361

2b Employer Identification Number (EIN) 95-3537304

2c Sponsor's telephone number (818) 889-8387

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.
a Sponsor's name
c Plan Name

4b EIN

4d PN

5a	Total number of participants at the beginning of the plan year	**5a**	4
b	Total number of participants at the end of the plan year	**5b**	4
c(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**5c(1)**	3
c(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**5c(2)**	3
d(1)	Total number of active participants at the beginning of the plan year	**5d(1)**	3
d(2)	Total number of active participants at the end of the plan year	**5d(2)**	3
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**5e**	0

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

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

SIGN HERE	Gerald C Berkman MD **Signature of plan administrator**	Date 10/21/2025	GERALD C. BERKMAN, M.D. Enter name of individual signing as plan administrator
SIGN HERE	**Signature of employer/plan sponsor**	Date	Enter name of individual signing as employer or plan sponsor

3. List names and titles of all officers of the company (an officer that is an administrative executive who is in "regular and continuous service" with the organization and has ability to make decisions regarding the company. This is not necessarily all employees with a title):

Name of Officer	Officer Title
Gerald E Berman MD	President

4. Controlled Group(s) may exist if a company's owners **or relatives of owners** have ownership in other companies. (These situations can be very complicated, we will contact you for more information based on the answer to this question.)

Did the company or any of its owners (or family members) acquire (or have) ownership in another business during the plan year? ☒ No ☐ Yes (If yes, complete table)

Owner Name	Company Name	# of Employees	Covered under this Plan?

Please add additional company ownership information on an attachment if necessary

5. Is your company part of an Affiliated Service Group (ASG) ☒ No ☐ Yes
An Affiliated Service Group refers to two or more organizations that have a service relationship and in some cases an ownership relationship. If you are unsure if your company is part of an ASG we can provide some basic information but you may need to seek legal counsel.

Payroll Information

NOTE: These totals should match the totals provided in the census file and be cross-checked with a final/YTD Payroll Report. If the numbers do not match, please research/correct any discrepancies prior to submitting the census.

1. Total Payroll (Gross Wages*) for the Plan Year: $ 52,730
*Gross wages is defined as W-2 Box 1 + Box 12 Code D (Pre-Tax Deferrals) + Section 125 deferrals (not reported on the W-2)

2. Total 401(k) Deferrals for the Plan Year: Pre-Tax-$_____ Roth-$ _____

Employer Contribution Information

1a. If you funded a Non-Safe Harbor Matching Contribution during the year, please indicate the formula:
_____% of First_____% of Deferrals and/or Amount:_____

1b. If you funded a Safe Harbor Matching Contribution during the year, please indicate the amount:

$_____

2. Will you be making a year-end **discretionary** contribution (not Safe Harbor) for this plan year? ☒ No

☐ Yes: Matching Contribution

☐ Please allocate the following amount $ _____

☐ Please use the following formula: _____ % of deferrals up to ____ % of Compensation

Employer Contribution Information (cont.)

☐ Yes: Profit Sharing

☐ Please calculate the maximum allowable contribution and advise

☐ Please allocate the following amount(s): $_____ or ____ %

☐ Please contact me regarding my options.

☐ Not Yet Determined: **Please notify Blue Chip when a final decision has been made.**

Do you intend to fund the contribution by your funding deadline ☐ or file an extension ☐

Forfeiture Use: Please indicate how you wish forfeitures to be used:

☐ Used to reduce current/future contributions

☐ Allocate to current eligible participants as ____ Matching or ____ Profit Sharing

☐ Use to pay plan fees

☐ Please contact me regarding my options.

3. Department of Labor have indicated that participant contributions (i.e.: Employee Pre-Tax Deferrals and loan payments) must be deposited to the plan as soon as it is reasonably possible to segregate them from company assets. A general "safe harbor" time frame is the 7th business day following withholding (for plans with fewer than 100 participants).

   There is a specific question on the 5500 Form relating to this subject which is why we are recommending that you review your plan's deposit procedure. Failure to comply with the Department of Labor deposit rules is a prohibited transaction and the company could be liable for lost income as well as excise taxes.

   Did the employer fail to transmit any participant contributions to the plan within the regulatory time period? ☐ No ☐ Yes If yes, please list below:

Payroll Date	Deposit Date	Amount of Deposit

Certified by: Harold Berkman MD Date: _____

(Signature of Employer)

Format as mm/dd/yyyy (leave blank if not applicable)	R=Retirement D=Death T=Quit/Fired DB=Disability Term ML=Military Leave/Term LOA=Leave of Absence	If applicable for Plan purposes	Y/N	Y/N
Status Change Date	**Status Change Reason**	**Division**	**Union Member**	**Owner**
[illegible]	[illegible]	N	N	Y
[illegible]	[illegible]	N	N	N
[illegible]	[illegible]	N	N	N

Format as xxx-xx-xxxx

Format usin

Plan Year Beg	Plan Year End	Social Security Number	First Name
02/01/2024	01/31/2025		Gerald
02/01/2024	01/31/2025		Renee
02/01/2024	01/31/2025		Sienna

New Employees:

Y/N		Total Wages For the Plan Year (including cafeteria plan deferrals, if applicable, as well as anything entered in Columns W-Z)	Please complete these columns only fo definition of compensation. Note tha		
Officer	**Ownership %**	**Gross Wages**	**Commissions**	**Overtime**	**Bonus**
Y	100.000				
N	0.000				
N	0.000				