

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 2025 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A	This return/report is for: ☒ a single-employer plan ☐ a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
B	This return/report is ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ DFVC program ☐ special extension (enter description)
D	If the plan is a collectively-bargained plan, check here ▶ ☐
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶ ☐

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan BRIDGEWATER INTERNAL MEDICINE, P.A. PROFIT SHARING PLAN	1b Three-digit plan number (PN) ▶ 001
		1c Effective date of plan 11/12/1993
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) BRIDGEWATER INTERNAL MEDICINE, P.A. 215 UNION AVENUE BRIDGEWATER, NJ 08807	2b Employer Identification Number (EIN) 22-3265741
		2c Sponsor's telephone number 908-526-8668
		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	4b EIN
		4d PN
5a	Total number of participants at the beginning of the plan year	5a 15
b	Total number of participants at the end of the plan year	5b 16
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) 15
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) 16
d(1)	Total number of active participants at the beginning of the plan year	5d(1) 14
d(2)	Total number of active participants at the end of the plan year	5d(2) 14
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.	01/28/2026	SMITHA GUBBI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/28/2026	SMITHA GUBBI
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	2017571	2504298
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	2017571	2504298
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	128750	
(2) Participants	8a(2)	81760	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	521996	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		732506
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	243723	
e Certain deemed and/or corrective distributions (see instructions) ..	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	2056	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		245779
i Net income (loss) (subtract line 8h from line 8c)	8i		486727
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristic Codes

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

Part V Compliance Questions

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

Part VI	Pension Funding Compliance		
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below.....			☐ Yes ☐ No
a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40.....		11a	
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 <u>06 / 30 / 2020</u> (MM/DD/YYYY) and the Opinion Letter serial number <u>Q703912A</u> .			

**Filing Authorization
for the 2025 Form 5500-SF**

Name of Plan: Bridgewater Internal Medicine, P.A. Profit Sharing Plan
EIN/PN: 22-3265741 / 001
PYE: 12/31/25

PART I Authorization of Practitioner to Electronically Sign and File

I hereby authorize Bury & Associates, Inc. to electronically sign and file the above-named return/reports through EFAST2.

I understand that in granting this authority that:

- I/we must manually sign the 5500-SF Forms and provide a scanned copy of that signature page to Bury & Associates, Inc.
- Bury & Associates, Inc. will retain a copy of this written authorization in its records;
- Bury & Associates, Inc. will notify the individual signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this annual return/report; and
- A copy of my signature will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
- Bury & Associates, Inc. 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 Plan year end stated above.

Plan Administrator: _____ Date: _____

Employer/Plan Sponsor (if not the Plan Administrator): *S. Subbitt* Date: 01/28/2026

PART II Acknowledgment of Receipt of Authorization

On behalf of Bury & Associates, Inc., I hereby certify that the firm will use the authority granted only for the express purposes described above; that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST filing; and that the firm will take reasonable steps to assure that confidential information provided by the Plan Administrator or Plan Sponsor is protected from unauthorized disclosure.

For Bury & Associates, Inc.: *[Signature]* Date: 1/28/26
(signature and title)

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

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D If the plan is a collectively-bargained plan, check here	☐	
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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) BRIDGEWATER INTERNAL MEDICINE, P.A. 215 UNION AVENUE BRIDGEWATER NJ 08807	1c	Effective date of plan <u>11/12/1993</u>
	2b	Employer Identification Number (EIN) <u>22-3265741</u>
	2c	Sponsor's telephone number <u>908-526-8668</u>
	2d	Business code (see instructions) <u>621111</u>
3a Plan administrator's name and address ☒ Same as Plan Sponsor.	3b	Administrator's EIN
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e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	5e	0

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

SIGN HERE	 Signature of plan administrator	<u>01/28/2026</u> Date	Smitha Gubbi Enter name of individual signing as plan administrator
SIGN HERE	 Signature of employer/plan sponsor	<u>01/28/2026</u> Date	Smitha Gubbi Enter name of individual signing as employer or plan sponsor