

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan 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). ▶ Complete all entries in accordance with the instructions to the Form 5500.	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 01/01/2020 and ending 12/31/2021	
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
1a	Name of plan PROB20Y
1b	Three-digit plan number (PN) ▶ 042
1c	Effective date of plan 01/01/2020
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) GURUPRASAD SRIHARI PROBUS TECHNICAL SERVICES INC PROBUS TECHNICAL SERVICES INC 836, 16TH MAIN ROAD BANASHANKARI 2 STAGE BANGALORE, KARNATAKA 560070 IN 210 W SIXTH STREET APT 302 ERIE, PA 16507
2b	Employer Identification Number (EIN) 38-3269858
2c	Plan Sponsor's telephone number +919482912724
2d	Business code (see instructions) 541190

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.	02/20/2026	GURUPRASAD SRIHARI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/20/2026	GURUPRASAD SRIHARI
	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 ☒ Same as Plan Sponsor		3b Administrator's EIN	
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		3c Administrator's telephone number 4b EIN 4d PN	
5 Total number of participants at the beginning of the plan year		5	6
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)	4
		6a(2)	4
		6b	
		6c	
		6d	4
		6e	
		6f	4
		6g(1)	4
		6g(2)	4
		6h	
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 Characteristic Codes in the instructions: 3B b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A			
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☒ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor		9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☒ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ 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

- (1)** ☒ **R** (Retirement Plan Information)
- (2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4)** ☐ **DCG** (Individual Plan Information) – Number Attached _____
- (5)** ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1)** ☒ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **A** (Insurance Information) – Number Attached _____
- (4)** ☐ **C** (Service Provider Information)
- (5)** ☐ **D** (DFE/Participating Plan Information)
- (6)** ☐ **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 2025 Form M-1 annual report. If the plan was not required to file the 2025 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 A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020		
A Name of plan PROB20Y	B Three-digit plan number (PN) ▶	042
C Plan sponsor's name as shown on line 2a of Form 5500 GURUPRASAD SRIHARI	D Employer Identification Number (EIN) 38-3269858	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier CHARLES LINK ASSOC					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
27-3486211		6 OO 71 I239960			

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4** 4500**5** Current value of plan's interest under this contract in separate accounts at year end **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶ **ASSETS FARMING, LAND, OTHER HOLDINGS, US GOVERNMENT SECURITIES****b** Premiums paid to carrier **6b** 600**c** Premiums due but unpaid at the end of the year **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d** 400Specify nature of costs ▶ **STATUS UPDATION RETURNS FILING****e** Type of contract: (1) ☒ individual policies (2) ☐ group deferred annuity(3) ☒ other (specify) ▶ **INVESTMENT WEALTH****f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☒ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b** 3000

c Additions: (1) Contributions deposited during the year	7c(1)	2000	
(2) Dividends and credits.....	7c(2)	450	
(3) Interest credited during the year.....	7c(3)	500	
(4) Transferred from separate account	7c(4)		
(5) Other (specify below).....	7c(5)		

▶

(6) Total additions **7c(6)** 2950**d** Total of balance and additions (add lines **7b** and **7c(6)**) **7d** 5950**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier.....	7e(2)	200	
(3) Transferred to separate account	7e(3)		
(4) Other (specify below).....	7e(4)		

▶

(5) Total deductions **7e(5)** 200**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f** 5750

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☒ Health (other than dental or vision)
b ☒ Dental
c ☒ Vision
d ☒ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	400	
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)	700	
(4) Earned ((1) + (2) - (3))	9a(4)		-300
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	200	
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)	50	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		250
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	9c(2)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		4000
(2) Claim reserves	9d(2)		2000
(3) Other reserves	9d(3)		1000
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	
Specify nature of costs.		

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE H (Form 5500) Department of the Treasury Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information 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.	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
For calendar plan year 2025 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2021</u>		
A Name of plan <u>PROB20Y</u>	B Three-digit plan number (PN) ► <u>042</u>	
C Plan sponsor's name as shown on line 2a of Form 5500 <u>GURUPRASAD SRIHARI</u>	D Employer Identification Number (EIN) <u>38-3269858</u>	

Part I Asset and Liability Statement			
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	2000	6500
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	2000	2400
(2) Participant contributions	1b(2)	1000	1200
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	800	1200
(2) U.S. Government securities	1c(2)	1600	1800
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	400	500
(6) Real estate (other than employer real property)	1c(6)	400	450
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	400	450
(2) Employer real property	1d(2)	500	550
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	9100	15050
Liabilities			
1g Benefit claims payable	1g	700	1200
1h Operating payables	1h	600	400
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through 1j)	1k	1300	1600
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	7800	13450

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. 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. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	5500	
(B) Participants	2a(1)(B)	4200	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)	400	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		10100
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	2000	
(B) U.S. Government securities	2b(1)(B)	3500	
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		5500
(2) Dividends: (A) Preferred stock	2b(2)(A)	1400	
(B) Common stock	2b(2)(B)	400	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	2600	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		4400
(3) Rents	2b(3)		2600
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	4500	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	1200	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	3400	
(B) Other	2b(5)(B)	600	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		29900

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	2600	
(2) To insurance carriers for the provision of benefits	2e(2)	1600	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		4200
f Corrective distributions (see instructions)	2f		200
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)	1000	
(2) Contract administrator fees	2i(2)	500	
(3) Recordkeeping fees	2i(3)	1000	
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	2500	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		5000
j Total expenses. Add all expense amounts in column (b) and enter total	2j		9400

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		20500
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☐ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name:

(2) EIN:

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

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.)			
4a			
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)			
4b			
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)			
4c			
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)			
4d			
e Was this plan covered by a fidelity bond?			
4e			
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			
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			
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			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)			
4i			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)			
4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
4k			
l Has the plan failed to provide any benefit when due under the plan?			
4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
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) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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 2025 This Form is Open to Public Inspection.
For calendar plan year 2025 or fiscal plan year beginning 01/01/2020 and ending 12/31/2021		
A Name of plan PROB20Y		B Three-digit plan number (PN) ▶ 042
C Plan sponsor's name as shown on line 2a of Form 5500 GURUPRASAD SRIHARI		D Employer Identification Number (EIN) 38-3269858
Part I	Distributions	
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
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
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.)	
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	
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.	
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		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule R (Form 5500) 2025 v. 250312		

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 **KALMAN HUJTER**

b EIN **23-7682545**

c Dollar amount contributed by employer **2000**

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) **50.00**

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

a Name of contributing employer **BREAKTHROUGH INC**

b EIN **20-0262626**

c Dollar amount contributed by employer **1000**

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: ☐ last contributing employer ☒ alternative ☐ reasonable approximation (see instructions for required attachment).....

14a

2

b The plan year immediately preceding the current plan year. ☐ 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. ☐ 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

2

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 ____/____/____ (MM/DD/YYYY) and the Opinion Letter serial number _____.

Landowner Report Summary

[Notification #2302572](#)

General Details

LOR Reporting Year:

2023

Town, Township, or Plantation:

Wayne

County:

Kennebec

Landowner Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

Physical Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Mailing Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

-
- This property **WAS** harvested during this year.
 - This harvest **WAS** completed this year.
 - There **WERE** non-harvest activities during this reporting year.

Method of Payment or Type of Sale:

This harvest was conducted under a contract for logging service (CLS)

Involvement Details

- A Written Management Plan **WAS** developed for this property.
- A Maine Licensed Forester **DID NOT** supervise this harvest.

Operator/Harvester Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

Physical Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Mailing Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Broker(s)/Exporter(s)

- Forest products **WERE NOT** exported outside of Maine or sold to a broker for export.

Activity Details

Harvest Information

Partial cut:

0 acres

Initial/Intermediate Shelterwood Harvest:

0 acres

Final/Overstory Removal Shelterwood Harvest:

0 acres

Clear Cut Harvest(s):

- 2 acres

Change of Land Use

2 acres

Non-Harvest Information

Herbicide Treatment:

Site Preparation:

1 acres

Release Acres:

1 acres

Non-Commercial Thinning:

1 acres

Tree Planting:

- 2 acres

Additional Information:

Saplings

Stumpage Details

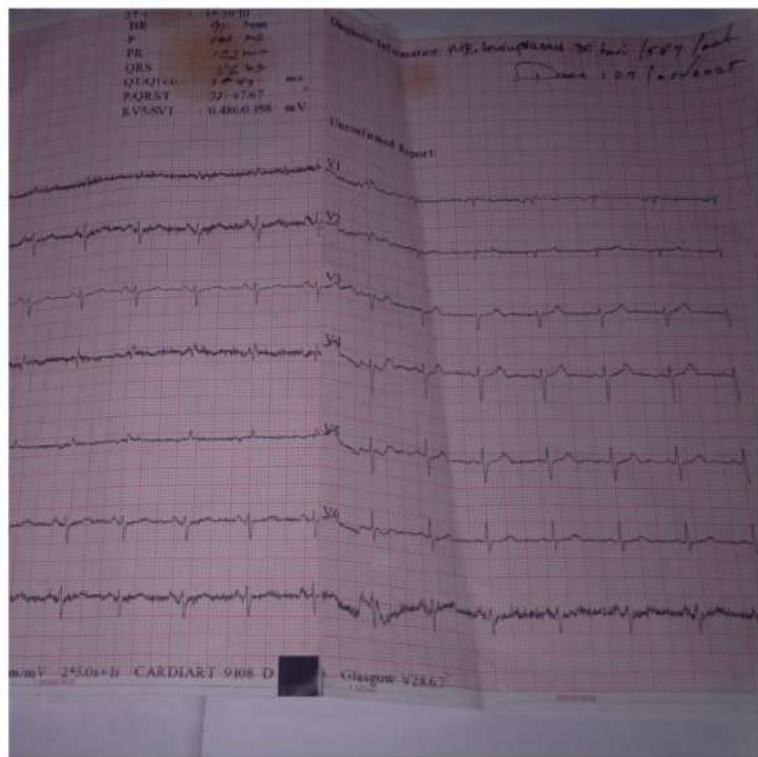
Stumpage is being reported using **ACTUAL** prices.

Standard Products

Product Type	Species/Group	Volume	Stumpage Price
Firewood	Softwood	60.00 cords	\$40.00 per cord
Biomass	Mixed Softwood/Hardwood	60.00 mlbs	\$25.00 per MLB (thousand pounds)

Specialty Products

Product Type	Species/Group	Units Harvested/Sold	Stumpage Price
No Specialty Products reported.			





INFOSYS CENTRAL LABORATORY
DEPARTMENT OF BIOCHEMISTRY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bengaluru, Karnataka, India

Patient Name : MR. GURU PRASAD
Age/Sex : 58 Yrs / Male
Phone No : 123
Doctor : Dr. VICTORIA

Bill No : 1757643
Patient ID : 837379
Collected On : 03-06-25 02:17
Reported On : 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE	
BIO-CHEMISTRY				
FBS: FASTING BLOOD SUGAR				
FBS: FASTING BLOOD SUGAR	98.2	mg/dL	78 - 109	
BIOCHEMISTRY Verified By				
BIOCHEMISTRY Certified By				
PPBS: POST PRANDIAL BLOOD SUGAR				
PPBS: POST PRANDIAL BLOOD SUGAR	123.8	mg/dL	< 140	
BIOCHEMISTRY Verified By				
BIOCHEMISTRY Certified By				
HBA1C				
HBA1C	6.0	%	5.0 - 5.9	
BIOCHEMISTRY Verified By				
BIOCHEMISTRY Certified By				
KIDNEY FUNCTION TEST (KFT)				
SERUM UREA	37	mg/dL	16.6 - 46.5	
SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9	
BIOCHEMISTRY Verified By				
BIOCHEMISTRY Certified By				
SERUM ELECTROLYTES				
SODIUM	139	mmol/L	136 - 145	



PHOSYS CENTRAL LABORATORY
DEPARTMENT OF MICROBIOLOGY
BANGKOK MEDICAL COLLEGE & SUTTHASITTHASIT
Venice Hospital Campus, K.R. Road, First
Bangkok, Thailand 10110

Form Name : MR. EUBO (MALL)
App/Spec : 158 Pte / 4160
Patient No : 111
Barcode : 10-00-000000
Ref No : 1111111111
Ref Date : 11/11/11
Ref Time : 11:11:11
Ref Unit : 1111111111
Ref Result : 1111111111
Ref Comment : 1111111111

TEST NAME :
UNIT :
REF UNIT :
REF RESULT :
REF COMMENT :

Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111
Sample Received	111	11/11/11	11:11:11	1111111111

TEST NAME :
UNIT :
REF UNIT :
REF RESULT :
REF COMMENT :

TEST NAME :
UNIT :
REF UNIT :
REF RESULT :
REF COMMENT :

TEST NAME :
UNIT :
REF UNIT :
REF RESULT :
REF COMMENT :



INFOSYS CENTRAL LABORATORY
DEPARTMENT OF BIOCHEMISTRY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bengaluru, Karnataka, India

Patient Name	: MR. GURU PRASAD	Bill No	: 1757643
Age/Sex	: 58 Yrs / Male	Patient ID	: 817379
Phone No	: 123	Collected On	: 03-06-25 02:17
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SA
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BIO-CHEMISTRY				
FBS: FASTING BLOOD SUGAR				
FBS: FASTING BLOOD SUGAR	98.2	mg/dL	78 - 109	0.0
Method: Spectrophotometry				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

PPFB: POST PRANDIAL BLOOD SUGAR				
PPFB: POST PRANDIAL BLOOD SUGAR	123.8	mg/dL	< 140	0.0
Method: Spectrophotometry				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

HBA1C				
HBA1C	6.0	%	5.0 - 5.9	0.0
Method: HPLC - Ion Exchange				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

KIDNEY FUNCTION TEST (KFT)				
SERUM UREA	37	mg/dL	16.6 - 46.5	0.0
Method: Spectrophotometry				

SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9	0.0
Method: Jaffe's Reaction				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

SERUM ELECTROLYTES				
SODIUM	139	mmol/L	136 - 145	0.0



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DEPARTMENT OF BIOCHEMISTRY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bengaluru, Karnataka, India

Patient Name : MR. GURU PRASAD
Age/Sex : 58 Yrs / Male
Phone No : 123
Doctor : Dr. VICTORIA

Bill No : 1757643
Patient ID : 437379
Collected On : 02-06-25 02:17 PM
Reported On : 03-06-25 11:28 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
SERUM ELECTROLYTES				
Method: ISE using potentiometric assay				
POTASSIUM	5.18	mmol/L	3.5 - 5.1	
Method: ISE using potentiometric assay				
CHLORIDE	103.0	mmol/L	96 - 107	
Method: ISE using potentiometric assay				
BIOCHEMISTRY			BIOCHEMISTRY	
Verified By			Certified By	
LIVER FUNCTION TEST				
TO TOTAL BILIRUBIN	0.30	mg/dL	up to 1.2	12.0.14
Method: JCA				
DI DIRECT BILIRUBIN	0.15	mg/dL	~ 0.10	
Method: JCA				
INDIRECT BILIRUBIN	0.2	mg/dL	0.20 - 0.80	
Method: Spectrophotometry				
TOTAL PROTEIN	7.5	g/dL	6.6 - 8.7	
Method: Broun				
ALBUMIN	4.8	g/dL	3.50 - 4.61	
Method: BSA				
GLOBULIN	2.7	g/dL	2.8 - 3.5	
Method: Serum and Cohn's				
A/G RATIO	1.8		1.5 : 1 to 2.5 : 1	
Method: Spectrophotometry				
ALP	77	U/L	Males - 40 - 129 Females - 35 - 105	
Method: JCA				
ASAT/AST	18	U/L	Males - upto 40 Females - upto 32	
Method: JCA, isothermally in serum, method of kinetic PLP activation				
ALP/ALP	12	U/L	Males - upto 41 Females - upto 33	
Method: JCA, isothermally in serum, method of kinetic PLP activation				



INFOSYS CENTRAL LABORATORY
DEPARTMENT OF PATHOLOGY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bengaluru, Karnataka, India

Patient Name	MR. GURU PRASAD	Bill No	1757643
Age/Sex	58 Yrs / Male	Patient ID	437379
Phone No	123	Collected On	02-06-25 02:17 PM
Doctor	Dr. VICTORIA	Reported On	03-06-25 11:26 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
HAEMATOLOGY				
MEAN PLATELET VOLUME	8.0	f	8.6 - 10.2	

Pathology Department - Hematology

Dr. PAVLOV
Verified By

Dr. PAVLOV
Certified By

*** End Of Report ***



INFOSYS CENTRAL LABORATORY
DEPARTMENT OF PATHOLOGY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bangalore, Karnataka, India

Patient Name	MR. GURU PRASAD	SR No	1757643
Age/Sex	58 Yrs / Male	Patient ID	437379
Phone No	123	Collected On	22-06-25 02:17 PM
Doctor	Dr. VICTORIA	Reported On	25-06-25 11:25 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
HAEMATOLOGY				
COMPLETE BLOOD COUNT				
HEMOGLOBIN PERCENTAGE	14.9	g/dl	13.0 - 17.0	
HEMOGLOBIN (g/dl) (AUTOMATED)				
PACKED CELL VOLUME	44.3	%	40 - 50	
MCV (fL) (AUTOMATED)				
RED BLOOD CELL COUNT	4.87	cells/mm ³	4.0 - 5.5	
RETICULOCYTE COUNT (AUTOMATED)				
MEAN CORPUSCULAR VOLUME	91.2	fL	80 - 100	
MCV (fL) (AUTOMATED)				
MEAN CORPUSCULAR HEMOGLOBIN	30.5	pg	29 - 34	
MCH (pg) (AUTOMATED)				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.4	g/dL	32 - 36	
MCHC (g/dL) (AUTOMATED)				
RED CELL DISTRIBUTION WIDTH	14.1	%	11.8 - 14	
RDW (fL) (AUTOMATED)				
TOTAL WBC COUNT	4800	cells/mm ³	4000 - 11000	
WBC (cells/mm ³) (AUTOMATED)				
NEUTROPHILS	45.1	%	35 - 77	
NEUT (fL) (AUTOMATED)				
LYMPHOCYTES	40.6	%	24 - 49	
LYM (fL) (AUTOMATED)				
MONOCYTES	8.8	%	0 - 9	
MON (fL) (AUTOMATED)				
EOSINOPHILS	3.7	%	0 - 5	
EOS (fL) (AUTOMATED)				
BASOPHILS	1.0	%	0 - 2	
BAS (fL) (AUTOMATED)				
ABSOLUTE NEUTROPHIL COUNT	2700	cells/mm ³	2000 - 7000	
NEUT (cells/mm ³)				
ABSOLUTE LYMPHOCYTE COUNT	2400	cells/mm ³	1000 - 3000	
LYM (cells/mm ³)				
ABSOLUTE MONOCYTE COUNT	600	cells/mm ³	200 - 1000	
MON (cells/mm ³)				
ABSOLUTE EOSINOPHIL COUNT	280	cells/mm ³	50 - 500	
EOS (cells/mm ³)				
ABSOLUTE BASOPHIL COUNT	100	cells/mm ³	20 - 100	
BAS (cells/mm ³)				
PLATELET COUNT	1.05	platelets/mm ³	1.0 - 4.0	
PLT (cells/mm ³)				