

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 09/01/2024 and ending 08/31/2025

- 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 [ ] 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: NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIFORNIA 403 B (7) RETIREMENT PLAN
1b Three-digit plan number (PN): 001
1c Effective date of plan: 09/01/1996
2a Plan sponsor's name (employer, if for a single-employer plan): NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIF.
2b Employer Identification Number (EIN): 94-2741597
2c Sponsor's telephone number: 415-989-8160
2d Business code (see instructions): 813000
3a Plan administrator's name and address: [X] Same as Plan Sponsor.
3b Administrator's EIN
3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.
4b EIN
4d PN
5a Total number of participants at the beginning of the plan year: 31
5b Total number of participants at the end of the plan year: 36
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item): 30
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item): 34
5d(1) Total number of active participants at the beginning of the plan year: 15
5d(2) Total number of active participants at the end of the plan year: 18
5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Row 1: Filed with authorized/valid electronic signature, 02/27/2026, ANDREA SALAS. Row 2: 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.)

| <b>Part III Financial Information</b>  |              |                              |                        |
|--|--------------|------------------------------|------------------------|
| <b>7</b> Plan Assets and Liabilities   |              | <b>(a) Beginning of Year</b> | <b>(b) End of Year</b> |
| <b>a</b> Total plan assets .....   | <b>7a</b>    | 2168043                      | 2751879                |
| <b>b</b> Total plan liabilities .....  | <b>7b</b>    |                              |                        |
| <b>c</b> Net plan assets (subtract line 7b from line 7a) .....                                       | <b>7c</b>    | 2168043                      | 2751879                |
| <b>8</b> Income, Expenses, and Transfers for this Plan Year  |              | <b>(a) Amount</b>            | <b>(b) Total</b>       |
| <b>a</b> Contributions received or receivable from:  |              |                              |                        |
| <b>(1)</b> Employers .....   | <b>8a(1)</b> | 130847                       |                        |
| <b>(2)</b> Participants .....  | <b>8a(2)</b> | 146319                       |                        |
| <b>(3)</b> Others (including rollovers) .....  | <b>8a(3)</b> |                              |                        |
| <b>b</b> Other income (loss) .....   | <b>8b</b>    | 332693                       |                        |
| <b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....                                  | <b>8c</b>    |                              | 609859                 |
| <b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) ..... | <b>8d</b>    | 25363                        |                        |
| <b>e</b> Certain deemed and/or corrective distributions (see instructions) .                         | <b>8e</b>    |                              |                        |
| <b>f</b> Administrative service providers (salaries, fees, commissions) .....                        | <b>8f</b>    | 660                          |                        |
| <b>g</b> Other expenses .....  | <b>8g</b>    |                              |                        |
| <b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....   | <b>8h</b>    |                              | 26023                  |
| <b>i</b> Net income (loss) (subtract line 8h from line 8c) .....                                     | <b>8i</b>    |                              | 583836                 |
| <b>j</b> Transfers to (from) the plan (see instructions) .....                                       | <b>8j</b>    |                              |                        |

| <b>Part IV Plan Characteristics</b> |   |
|-------------------------------------|---|
| <b>9a</b>                           | If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:<br>2M |
| <b>b</b>                            | If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:       |

| <b>Part V Compliance Questions</b>  |            |            |           |               |
|---|------------|------------|-----------|---------------|
| <b>10</b> During the plan year:   |            | <b>Yes</b> | <b>No</b> | <b>Amount</b> |
| <b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) ..... | <b>10a</b> |            | X         |               |
| <b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....  | <b>10b</b> |            | X         |               |
| <b>c</b> Was the plan covered by a fidelity bond? .....   | <b>10c</b> |            | X         |               |
| <b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....   | <b>10d</b> |            | X         |               |
| <b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....   | <b>10e</b> | X          |           | 660           |
| <b>f</b> Has the plan failed to provide any benefit when due under the plan? .....  | <b>10f</b> |            | X         |               |
| <b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....  | <b>10g</b> |            | X         |               |
| <b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....  | <b>10h</b> |            | X         |               |
| <b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....   | <b>10i</b> |            | X         |               |

**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 \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) and the Opinion Letter serial number \_\_\_\_\_.

## Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits

This form is required to be filed under section 6057 of the Internal Revenue Code.  
Go to [www.irs.gov/Form8955SSA](http://www.irs.gov/Form8955SSA) for instructions and the latest information.

# 2024

This Form is NOT Open  
to Public Inspection

### PART I Annual Statement Identification Information

For the plan year beginning 09/01/2024, and ending 08/31/2025

- A**  Check here if plan is a government, church, or other plan that elects to voluntarily file Form 8955-SSA. (See instructions.)
- B**  Check here if this is an amended registration statement.
- C** Check the appropriate box if filing under:  Form 5558  Automatic extension  
 Special extension (enter description)

### PART II Basic Plan Information - enter all requested information

|  |  |
|--|--|
| <b>1a</b> Name of plan<br><b>NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIFORNIA 403 B (7)</b> | <b>1b</b> Plan Number (PN)<br><b>001</b> |
|--|--|

#### Plan Sponsor Information

|   |   |
|---|---|
| <b>2a</b> Plan sponsor's name<br><b>NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIF.</b> | <b>2b</b> Employer Identification Number (EIN)<br><b>94-2741597</b> |
| <b>2c</b> Trade name (if different from plan sponsor name)                                | <b>2d</b> Plan sponsor's phone number<br><b>415-989-8160</b>        |

**2e** In care of name

|  |  |                               |                                    |
|--|--|-------------------------------|------------------------------------|
| <b>2f</b> Mailing address (room, apt., suite no. and street, or P.O. box)<br><b>49 STEVENSON STREET, SUITE 500</b> | <b>2g</b> City<br><b>SAN FRANCISCO</b> | <b>2h</b> State<br><b>CA</b>  | <b>2i</b> ZIP code<br><b>94105</b> |
| <b>2j</b> Foreign province (or state)  | <b>2k</b> Foreign country              | <b>2l</b> Foreign postal code |                                    |

#### Plan Administrator Information

|   |  |
|---|--|
| <b>3a</b> Plan administrator's name (if other than plan sponsor)<br><b>SAME</b> | <b>3b</b> Employer Identification Number (EIN) |
| <b>3c</b> In care of name   | <b>3d</b> Plan administrator's phone number    |

|   |                           |                               |                    |
|---|---------------------------|-------------------------------|--------------------|
| <b>3e</b> Mailing address (room, apt., suite no. and street, or P.O. box) | <b>3f</b> City            | <b>3g</b> State               | <b>3h</b> ZIP code |
| <b>3i</b> Foreign province (or state)                                     | <b>3j</b> Foreign country | <b>3k</b> Foreign postal code |                    |

**4** If the name or EIN of the **plan administrator** has changed since the last return filed for this plan, enter the name and EIN from the last filed return:

|                           |     |
|---------------------------|-----|
| Plan administrator's name | EIN |
|---------------------------|-----|

**5** If the name or EIN of the **plan sponsor** has changed since the last return filed for this plan, enter the name, EIN, and plan number from that return:

|                     |     |                  |
|---------------------|-----|------------------|
| Plan sponsor's name | EIN | Plan Number (PN) |
|---------------------|-----|------------------|

|   |   |                             |
|---|---|-----------------------------|
| <b>6a</b> Participants who separated with a deferred vested benefit required to be reported on this Form 8955-SSA   | <b>6a</b>                               | <b>4</b>                    |
| <b>b</b> Participants who separated with a deferred vested benefit voluntarily reported on this Form 8955-SSA in the same year as the separation occurred | <b>6b</b>                               |                             |
| <b>7</b> Total number of participants reported on lines 6a and 6b   | <b>7</b>                                | <b>4</b>                    |
| <b>8</b> Did the plan administrator provide an individual statement to each participant required to receive a statement?                                  | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

**Under penalties of perjury, I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, and complete.**

|                  |                           |             |                                     |                               |
|------------------|---------------------------|-------------|-------------------------------------|-------------------------------|
| <b>Sign Here</b> | Signature of plan sponsor | Date signed | Signature of plan administrator<br> | Date signed<br><b>2/27/26</b> |
|------------------|---------------------------|-------------|-------------------------------------|-------------------------------|

|   |  |   |
|---|--|---|
| <b>Form 5500-SF</b><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Short Form Annual Return/Report of Small Employee Benefit Plan</b><br><br>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).<br><br><b>Complete all entries in accordance with the instructions to the Form 5500-SF.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|---|--|---|

**Part I Annual Report Identification Information**

For calendar plan year 2024 or fiscal plan year beginning **09/01/2024** and ending **08/31/2025**

**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**

|   |  |              |
|---|--|--------------|
| <b>1a</b> Name of plan<br>NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIFORNIA 403 B (7) RETIREMENT PLAN   | <b>1b</b> Three-digit plan number (PN)         | 001          |
|   | <b>1c</b> Effective date of plan               | 09/01/1996   |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instr.)<br>NON-PROFIT HOUSING ASSOCIATION OF NORTHERN CALIF<br>49 STEVENSON STREET, SUITE 500<br><br>SAN FRANCISCO CA 94105 | <b>2b</b> Employer Identification Number (EIN) | 94-2741597   |
|   | <b>2c</b> Sponsor's telephone number           | 415-989-8160 |
|   | <b>2d</b> Business code (see instructions)     | 813000       |
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.   | <b>3b</b> Administrator's EIN                  |              |
|   | <b>3c</b> Administrator's telephone number     |              |
| <b>4</b> 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.<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name  | <b>4b</b> EIN                                  |              |
|   | <b>4d</b> PN                                   |              |
| <b>5a</b> Total number of participants at the beginning of the plan year  | <b>5a</b>                                      | 31           |
| <b>b</b> Total number of participants at the end of the plan year   | <b>5b</b>                                      | 36           |
| <b>c (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)   | <b>5c(1)</b>                                   | 30           |
| <b>c (2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)   | <b>5c(2)</b>                                   | 34           |
| <b>d (1)</b> Total number of active participants at the beginning of the plan year  | <b>5d(1)</b>                                   | 15           |
| <b>d (2)</b> Total number of active participants at the end of the plan year  | <b>5d(2)</b>                                   | 18           |
| <b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested  | <b>5e</b>                                      |              |

**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.

|                  |                                    |         |  |
|------------------|------------------------------------|---------|--|
| <b>SIGN HERE</b> |                                    | 2/27/26 | ANDREA SALAS   |
|                  | Signature of plan administrator    | Date    | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |                                    |         |  |
|                  | Signature of employer/plan sponsor | Date    | Enter name of individual signing as employer or plan sponsor |