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

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2000 and ending 12/31/2010

A This return/report is for:
- [ ] a multiemployer plan
- [X] 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:
- [X] the first return/report
- [X] 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
- [X] 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
PROBCLIENTOY00TT09

1b Three-digit plan number (PN) ▶ 056

1c Effective date of plan 01/01/2000

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

CLIENTO FINANCIAL LLC SERIES

GULF GROUP HOLDINGS

836, 16TH MAIN ROAD BANASHANKARI 2 STAGE
BANGALORE, KARNATAKA 560070 IN

50 W 3900
STE 3B
SALT LAKE CITY, UT 84107

2b Employer Identification Number (EIN)
27-4300000

2c Plan Sponsor's telephone number
+919482912724

2d Business code (see instructions)
525920

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.	03/13/2026	GURUPRASAD SRIHARI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	03/13/2026	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 [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
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	8
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	**6a(1)**	8
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	8
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	8
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	4
f	Total. Add lines **6d** and **6e**.	**6f**	12
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	4
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	4
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:

2V 2T

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

4A 4Q

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	**(1)**	[X] Insurance
(2)	[X] Code section 412(e)(3) insurance contracts	**(2)**	[X] Code section 412(e)(3) insurance contracts
(3)	[ ] Trust	**(3)**	[ ] Trust
(4)	[ ] General assets of the sponsor	**(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)** [X] **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)** [X] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached _____
- **(4)** [X] **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

For calendar plan year 2025 or fiscal plan year beginning 01/01/2001 and ending 12/31/2020

A Name of plan
PROBCLIENTOY00TT09

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
27-4300000

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.

1 Coverage Information:

(a) Name of insurance carrier
CLIENTO FINANCIAL LLC SERIES

(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
27-4300000	52211	AO 10929%	10	01/01/2010	01/01/2019

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
12000	1000

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

CLIENTO FINANCIAL LLC SERIES
50 W 3900 STE3B
SALT LAKE CITY, UT 84107

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3200	200	PERFORES STAT S CRAN WHIT EXAMPTS TAX PRO RESOURCE RAW ORES EMBOWED DEEDS LAUDS HIGH PRINE PEROSES STAN C	2

(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	15000
5	Current value of plan's interest under this contract in separate accounts at year end	5	14000

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ RESOURCE CRUDE RAW PURE SELF WHIT STAN CE ORE COMPOSITES SILVER RARE MINERAL NON EXCAVATION ENSIGNS

b	Premiums paid to carrier	6b	1400
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	600

Specify nature of costs ▶ EXCAVATION BASIC ORE SHORING EMBOWS ENSIGNS SELF STAN CE WHITS SEN ADM AFFAIRS RACTIFICATIONS EXAMPT

e Type of contract: (1) [X] individual policies (2) [ ] group deferred annuity

(3) [X] other (specify) ▶ INNDENTS PERFORE EMBOWS LAU DS EMINITY ENSIGNS RUDES HIGH LEVELS IMMUNITY US GOVMNT MAS KS SELF PHYSQ

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) [X] deposit administration (2) [ ] immediate participation guarantee

(3) [X] guaranteed investment (4) [ ] other ▶

b	Balance at the end of the previous year			7b	25000
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below) ▶	7c(5)			
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	25000
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1000		
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below) ▶	7e(4)			
	(5) Total deductions			7e(5)	1000
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	24000

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 [X] Health (other than dental or vision)	**b** [X] Dental	**c** [X] Vision	**d** [X] 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** [X] Indemnity contract

m [X] Other (specify) ▶ PERFORES PHYSQ R CE MASK WHIT S NATURAL PERVASE STAT NO FRINGE EMBOWS LAUDS PERORES STAN CE ORDS RILES

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	2000		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	2000
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)**	650		
(B) Administrative service or other fees	**9c(1)(B)**	600		
(C) Other specific acquisition costs	**9c(1)(C)**	150		
(D) Other expenses	**9c(1)(D)**	400		
(E) Taxes	**9c(1)(E)**	400		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	2200
(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)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
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 [X] No

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

SCHEDULE MB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2000 and ending 12/31/2009

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
PROBCLIENTOY00TT09

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
27-4300000

E Type of plan: **(1)** [X] Multiemployer Defined Benefit **(2)** [ ] Money Purchase (see instructions)

1a Enter the valuation date: Month 01 Day 01 Year 1991

b	Assets		
(1)	Current value of assets	**1b(1)**	10000
(2)	Actuarial value of assets for funding standard account	**1b(2)**	7000
c	**(1)** Accrued liability for plan using immediate gain methods	**1c(1)**	6000
(2)	Information for plans using spread gain methods:		
(a)	Unfunded liability for methods with bases	**1c(2)(a)**	2600
(b)	Accrued liability under entry age normal method	**1c(2)(b)**	1200
(c)	Normal cost under entry age normal method	**1c(2)(c)**	900
(3)	Accrued liability under unit credit cost method	**1c(3)**	
d	Information on current liabilities of the plan:		
(1)	Amount excluded from current liability attributable to pre-participation service (see instructions)	**1d(1)**	800
(2)	"RPA '94" information:		
(a)	Current liability	**1d(2)(a)**	1400
(b)	Expected increase in current liability due to benefits accruing during the plan year	**1d(2)(b)**	300
(c)	Expected release from "RPA '94" current liability for the plan year	**1d(2)(c)**	400
(3)	Expected plan disbursements for the plan year	**1d(3)**	600

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE

Signature of actuary	Date: 01/01/2000
GURUPRASAD SRIHARI	24-75494
Type or print name of actuary	Most recent enrollment number
CLIENTO FINANCIAL LLC SERIES	+919482912724
Firm name	Telephone number (including area code)
50 W 3900 STE3 B SALT LAKE CITY, UT 84107	
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)		**2a**	16000
b "RPA '94" current liability/participant count breakdown:		**(1)** Number of participants	**(2)** Current liability
(1) For retired participants and beneficiaries receiving payment		2	
(2) For terminated vested participants			
(3) For active participants:			
(a) Non-vested benefits			2500
(b) Vested benefits			6500
(c) Total active		2200	9000
(4) Total		2202	9000
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage		**2c**	%

3 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM/DD/YYYY)	**(b)** Amount paid by employer(s)	**(c)** Amount paid by employees	**(a)** Date (MM/DD/YYYY)	**(b)** Amount paid by employer(s)	**c)** Amount paid by employees
01/01/2000	850	1200			
			Totals ► **3(b)**	850	**3(c)** 1200
(d) Total withdrawal liability amounts included in line 3(b) total					**3(d)** 200

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	**4a**	0.0 %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	**4b**	N

c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? ☐ Yes ☒ No

d If the plan is in critical status or critical and declining status, does line 1(c) reflect any benefit reductions for the first time (see instructions)? ☐ Yes ☒ No

e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	**4e**	
f If the plan is in critical status or critical and declining status, and is: • Projected to emerge from critical status within 30 years, enter the plan year in which it is projected to emerge; • Projected to become insolvent within 30 years, enter the plan year in which insolvency is expected and check here ☐ • Neither projected to emerge from critical status nor become insolvent within 30 years, enter "9999."	**4f**	

5 Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

a ☒ Attained age normal **b** ☒ Entry age normal **c** ☒ Accrued benefit (unit credit) **d** ☒ Aggregate

e ☐ Frozen initial liability **f** ☐ Individual level premium **g** ☒ Individual aggregate **h** ☐ Shortfall

i ☐ Other (specify):

j If box h is checked, enter period of use of shortfall method	**5j**	

k Has a change been made in funding method for this plan year? ☐ Yes ☒ No

l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? ☐ Yes ☐ No

m If line k is "Yes," and line l is "No," enter the date (MM/DD/YYYY) of the ruling letter (individual or class) approving the change in funding method	**5m**	

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability		**6a**	4.00 %
		Pre-retirement	Post-retirement
b Rates specified in insurance or annuity contracts		[X] Yes [ ] No [ ] N/A	[X] Yes [ ] No [ ] N/A
c Mortality table code for valuation purposes:			
(1) Males	**6c(1)**	AD12J5	AD12J5
(2) Females	**6c(2)**	AD12J5	AD12J5
d Valuation liability interest rate	**6d**	3.50 %	3.00 %
e Salary scale	**6e**	4.50 % [ ] N/A	
f Withdrawal liability interest rate:			
(1) Type of interest rate	**6f(1)**	[ ] Single rate [ ] ERISA 4044 [ ] Other [X] N/A	
(2) If "Single rate" is checked in (1), enter applicable single rate	**6f(2)**	%	
g Estimated investment return on actuarial value of assets for year ending on the valuation date	**6g**	2.5 %	
h Estimated investment return on current value of assets for year ending on the valuation date	**6h**	2.0 %	
i Expense load included in normal cost reported in line 9b	**6i**	[ ] N/A	
(1) If expense load is described as a percentage of normal cost, enter the assumed percentage	**6i(1)**	%	
(2) If expense load is a dollar amount that varies from year to year, enter the dollar amount included in line 9b	**6i(2)**		
(3) If neither (1) nor (2) describes the expense load, check the box	**6i(3)**	[ ]	

7 New amortization bases established in the current plan year:

(1) Type of base	**(2)** Initial balance	**(3)** Amortization Charge/Credit

8 Miscellaneous information:

a If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM/DD/YYYY) of the ruling letter granting the approval	**8a**	
b Demographic, benefit, and contribution information		
(1) Is the plan required to provide a projection of expected benefit payments? (See instructions) If "Yes," see instructions for required attachment.		[ ] Yes [X] No
(2) Is the plan required to provide a Schedule of Active Participant Data? (See instructions).		[ ] Yes [X] No
(3) Is the plan required to provide a projection of employer contributions and withdrawal liability payments? (See instructions) If "Yes," attach a schedule.		[ ] Yes [X] No
c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?		[ ] Yes [X] No
d If line c is "Yes," provide the following additional information:		
(1) Was an extension granted automatic approval under section 431(d)(1) of the Code?		[ ] Yes [ ] No
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended	**8d(2)**	
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?		[ ] Yes [ ] No
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	**8d(4)**	
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension	**8d(5)**	
(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?		[ ] Yes [ ] No
e If box 5h is checked or the plan received an amortization extension for this plan year under Code section 431(d), enter the difference between the amount necessary to satisfy the plan's minimum funding standard for this plan year and the amount that would have been necessary without using the shortfall method or extending the amortization period(s).	**8e**	

9 Funding standard account statement for this plan year:

Charges to funding standard account:

a Prior year funding deficiency, if any	**9a**	
b Employer's normal cost for plan year as of valuation date	**9b**	2300

c Amortization charges as of valuation date:		Outstanding balance		
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	**9c(1)**	4200		5600
(2) Funding waivers	**9c(2)**	1200		1300
(3) Certain bases for which the amortization period has been extended	**9c(3)**			
d Interest as applicable on lines 9a, 9b, and 9c			**9d**	650
e Total charges. Add lines 9a through 9d			**9e**	9850
Credits to funding standard account:				
f Prior year credit balance, if any			**9f**	
g Employer contributions. Total from column (b) of line 3			**9g**	850
		Outstanding balance		
h Amortization credits as of valuation date	**9h**	700		750
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h			**9i**	250
j Full funding limitation (FFL) and credits:				
(1) ERISA FFL (accrued liability FFL)	**9j(1)**			
(2) "RPA '94" override (90% current liability FFL)	**9j(2)**			
(3) FFL credit			**9j(3)**	
k (1) Waived funding deficiency			**9k(1)**	
(2) Other credits			**9k(2)**	
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)			**9l**	1850
m Credit balance: If line 9l is greater than line 9e, enter the difference			**9m**	
n Funding deficiency: If line 9e is greater than line 9l, enter the difference			**9n**	8000
o Current year's accumulated reconciliation account:				
(1) Due to waived funding deficiency accumulated prior to the current plan year			**9o(1)**	
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:				
(a) Reconciliation outstanding balance as of valuation date			**9o(2)(a)**	400
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))			**9o(2)(b)**	-400
(3) Total as of valuation date			**9o(3)**	-400
10 Contribution necessary to avoid an accumulated funding deficiency. (see instructions.)			**10**	

11 Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions ☐ Yes ☒ No

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/2000 and ending 12/31/2010

A Name of plan	**B** Three-digit plan number (PN) ▶	
PROBCLIENTOY00TT09		056
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
GURUPRASAD SRIHARI	27-4300000	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☐ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

GURUPRASAD SRIHARI

836, 16TH MAIN ROAD, BSK 2 STAGE
BENGALURU, KARNATAKA 560070 IN

38-3269858

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

HEALTH SAGE CONSULTING INC

50 CIR SW
PARK CITY, UTAH US

27-3959113

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
40	OFFICIAL	12000	Yes [X] No [ ]	Yes [X] No [ ]	2000	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
GURUPRASAD SRIHARI	40	4000

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CLIENTO FINANCIAL LLC SERIES 50 W 3900 STE3B SALT LAKE CITY, UT 84107 27-4300000	WHITS PERORE REGULATED HIGH STATUS AVERAGE DEPOSITS. ORE, OIL, RESOURCES, RAW DISTILL, ADHERENCE US CONSTITUTIONAL IMMUNITY

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
HEALTHCARE SAGE CONSULTING INC	40	

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
GURUPRASAD SRIHARI 50 CIR SW PARK CITY, UT 84060 US 27-3959113	SERVICES AS US CONGRESS, LEGAL AMENDMENTS RILED TO SENATE COUNCIL, STATE LAWS AS FORMULA STATUS PARED INDEMNITY ENTIRETY. PERSONAL CRAN S STAN CE APPROVED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE DCG (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Individual Plan Information

This schedule is required to be filed under section 103 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

Part I DCG Information

A Name of DCG
PROBCLIENTOY00TT09

B Three-digit plan number (PN) ▶ 056

C DCG Sponsor's Name (enter here only if different from Name of DCG)
GURUPRASAD SRIHARI

D Employer Identification Number (EIN) for DCG
27-4300000

Part II Individual Schedule DCG Information. Complete a separate Schedule for each individual defined contribution pension plan.

E This Schedule DCG is for: ☐ a single-employer plan ☒ a collectively-bargained plan

F This Schedule DCG is: ☒ the first Schedule ☒ the final Schedule ☐ an amended Schedule

Part III Basic Individual Plan Information

1a Name of plan
PROBUSGORMANY50

1b Three-digit plan number (PN) 072

1c Effective date of plan 01/01/1950

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
FRANCIS P GORMAN ESTATE
FRANCIS P GORMAN
836, 16TH MAIN ROAD BANASHANKARI 2 STAGE
BENGALURU, KARNATAKA 560070 IN
132 SHERMAN ROAD
ENFIELD, CT 06082

2b Employer Identification Number (EIN) 45-6577522

2c Plan sponsor's telephone number +919482912724

2d Business code 531390

3 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 Plan sponsor's name
c Plan Name

3b EIN

3d PN

4a Plan administrator's name and address
FRANCIS P GORMAN ESTATE
FRANCIS P GORMAN
142 SHERMAN ROAD
ENFIELD, CT 06082

4b EIN 45-6577522

4c Administrator's telephone number +919482912724

5a	Total number of participants at the beginning of the plan year	**5a**	6
b	Total number of participants as of the end of the plan year	**5b**	6
c(1)	Total number of active participants at the beginning of the plan year	**5c(1)**	4
c(2)	Total number of active participants at the end of the plan year	**5c(2)**	4
d(1)	Number of participants with account balances as of the beginning of the plan year	**5d(1)**	4
d(2)	Number of participants with account balances as of the end of the plan year	**5d(2)**	4
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**5e**	

Part IV Financial Information

6	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a	Total plan assets	6a	40000	45000
	(1) Participant loans	6a(1)		
b	Total plan liabilities	6b	14000	13500
c	Net Assets (subtract line 6b from line 6a)	6c	26000	31500

7a	Contributions received or receivable in cash from		Amount
	(1) Employers	7a(1)	4000
	(2) Participants	7a(2)	1000
	(3) Others (including rollovers)	7a(3)	0
b	Noncash contributions	7b	1500
c	Total Contributions (add lines 7a(1)-(3) and line 7(b))	7c	6500
d	Other income (loss)	7d	6000
e	Total Income (add lines 7c and 7d)	7e	12500
f	Benefit payment and payments to provide benefits	7f	2000
g	Corrective distributions (see instructions)	7g	
h	Certain deemed distributions of participant loans (see instructions)	7h	
i	Administrative service provider's expense (salaries, fees, commissions)	7i	400
j	Other expenses	7j	
k	Total expenses (add lines 7f, 7g, 7h, 7i, and 7j)	7k	2400
l	Net income (loss) (subtract line 7k from line 7e)	7l	10100
m	Transfers of assets		
	(1) To this plan	7m(1)	3000
	(2) From this plan	7m(2)	

Part V Plan Characteristic Codes

8 Enter the applicable two-character feature codes from the List of Plan Characteristic Codes in the instructions.

3D

Part VI Compliance Questions

			Yes	No	Amount
9a	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.)	9a		X	
b	Were there any nonexempt transactions with any party-in-interest?	9b		X	
c	Has the plan failed to provide any benefit when due under the plan?	9c		X	
d	Was the plan covered by a fidelity bond?	9d	X		20000
e	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	9e		X	

10 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)

10a Name of plan(s)	10b EIN(s)	10c PN(s)

11 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code? ☐ Yes ☒ No

12a 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

12b 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

13 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 _____.

Part VII Accountant Opinion Information for Participating Plans

14 Is the plan required to attach a report of an independent qualified public accountant (IQPA)? (See instructions on eligibility and condition for waiver of the annual examination and report of an IQPA under 29 CFR 2520.104-46):

☐ Yes ☒ No

Complete lines 14a through 14c if you checked "YES" and the report of an IQPA for the plan is required to be attached to this Schedule DCG.

a The opinion reflected in the attached report of an IQPA 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:

Landowner Report Summary

Notification #2302485

General Details

LOR Reporting Year:
2023

Town, Township, or Plantation:
T4 R7 WELS

County:
Penobscot

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:
Landowner did not cut the trees but received payment for them

Involvement Details

- A Written Management Plan **WAS** developed for this property.
- A Maine Licensed Forester **DID** supervise this harvest.

Licensed Forester / License Number:
Guruprasad Srihari / FI9844025722

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:
0.5 acres

Initial/Intermediate Shelterwood Harvest:
0.5 acres

Final/Overstory Removal Shelterwood Harvest:
1 acres

Clear Cut Harvest(s):

1. 1 acres

Change of Land Use

0.5 acres

Non-Harvest Information

Herbicide Treatment:

Site Preparation:
2 acres

Release Acres:
1 acres

Non-Commercial Thinning:
0.4 acres

Tree Planting:

1. : 1 acres
2. : 1 acres

Additional Information:
Tree proximity to water, soil conditions addressed

Stumpage Details

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

Standard Products

Product Type	Species/Group	Volume	Stumpage Price
Veneer	Red Oak	240.00 board feet	$6500.00 per MBF (thousand board feet)
Veneer	Red/White Maple	10000.00 board feet	$4600.00 per MBF (thousand board feet)
Sawlogs	Other Softwood	900.00 board feet	$3200.00 per MBF (thousand board feet)
Sawlogs	Ash	1200.00 board feet	$3200.00 per MBF (thousand board feet)

Palletwood	Hardwood	2500.00 board feet	$8500.00 per MBF (thousand board feet)
Palletwood	Softwood	3200.00 green tons	$2000.00 per green ton
Studwood	Cedar	4600.00 green tons	$14500.00 per green ton
Studwood	Beech	2600.00 cords	$8500.00 per cord
Boltwood	Aspen/Poplar	2100.00 board feet	$2600.00 per MBF (thousand board feet)
Pulpwood	White Pine	1500.00 green tons	$600.00 per green ton
Firewood	Softwood	8000.00 green tons	$1500.00 per green ton
Firewood	Hardwood	6000.00 cords	$2100.00 per cord
Biomass	Mixed Softwood/Hardwood	5600.00 green tons	$1100.00 per green ton
Biomass	Mixed Softwood/Hardwood	560.00 mlbs	$500.00 per MLB (thousand pounds)

Specialty Products

Product Type	Species/Group	Units Harvested/Sold	Stumpage Price
	Red Pine	2100.00 cords	$7500.00 per cord
	Beech	1250.00 green tons	$1200.00 per green ton
	Other Hardwood	5600.00 board feet	$750.00 per MBF (thousand board feet)
	Hemlock	7000.00 mlbs	$3100.00 per MLB (thousand pounds)

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	: 50 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SA
	BIO-CHEMISTRY			
FBS: FASTING BLOOD SUGAR				
FBS: FASTING BLOOD SUGAR	90.2	mg/dL	74 - 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	%	4.8 - 5.9	
BIOCHEMISTRY Certified By			BIOCHEMISTRY Certified By	
RENAL FUNCTION TEST (RFT)				
SERUM UREA	37	mg/dL	16.6 - 48.5	
SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9	
BIOCHEMISTRY Certified By			BIOCHEMISTRY Certified By	
SERUM ELECTROLYTES				
SODIUM	139	mmol/L	136 - 145	

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF BIOCHEMISTRY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bangalore,Karnataka,India

Patient Name	: Mr. GIRISH PRASAD	Bill No	: 1753649
Age/Sex	: 38 Yrs / Male	Patient ID	: 457379
Phone No	: 123	Collected On	: 22-04-25 10:17 PM
Doctor	: Dr. VICTORIA	Reported On	: 22-04-25 11:25 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
Verified By			Certified By	
LIVER PROFILE				
[illegible]	224	mg/dL	< 230	
[illegible]	166.4	mg/dL	[illegible]	
[illegible]	48	mg/dL	[illegible]	
[illegible]	36	mg/dL		
[illegible]	142	mg/dL	< 200	
Verified By			Certified By	

*** End Of Report ***

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	: 50 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE
	BIO-CHEMISTRY		
FBS: FASTING BLOOD SUGAR			
FBS: FASTING BLOOD SUGAR	90.2	mg/dL	74 - 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	%	4.8 - 5.9
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By
RENAL FUNCTION TEST (RFT)			
SERUM UREA	37	mg/dL	16.6 - 48.5
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

INFOSYS CENTRAL LABORATORY

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

ient Name	: MR. GURU PRASAD	Bill No	: 1757643
e/Sex	: 58 Yrs / Male	Patient ID	: 437379
ne No	: 123	Collected On	: 02-06-25 02:37 PM
ctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:28 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
SERUM ELECTROLYTES				
POTASSIUM	5.18	mmol/L	3.5 - 5.1	
CHLORIDE	103.0	mmol/L	98 - 107	

BIOCHEMISTRY
Verified By

BIOCHEMISTRY
Certified By

LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.50	mg/dL	up to 1.2	SERUM
DIRECT BILIRUBIN	0.15	mg/dL	<= 0.30	
INDIRECT BILIRUBIN	0.2	mg/dL	0.20 - 0.80	
TOTAL PROTEIN	7.5	g/dL	6.6 - 8.7	
ALBUMIN	4.8	g/dL	3.56 - 4.61	
GLOBULIN	2.7	g/dL	2.0 - 3.5	
A/G RATIO	1.8		1.5 : 1 to 2.5 : 1	
ALP	77	U/L	Males - 40 - 129 Females - 35 - 105	
SGOT/AST	18	U/L	Males - upto 46 Females - upto 32	
SGPT/ALT	12	U/L	Males - upto 41 Females - upto 33	

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
Ward/Bed 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	9.0	fl	6.6 - 10.2	

Dr. PHILOMIN
Verified By

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Certified By

*** End Of Report ***

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	BAR No	: 1757643
Age/Sex	: 59 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17 PM
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:25 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
HAEMATOLOGY				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN PERCENTAGE	14.8	g/dL	13.0 - 17.0	
PACKED CELL VOLUME	44.5	%	40 - 50	
RED BLOOD CELL COUNT	4.97	million/cumm	4.5 - 5.5	
MEAN CORPUSCULAR VOLUME	91.5	fl	83 - 101	
MEAN CORPUSCULAR HAEMOGLOBIN	30.5	pg	27 - 32	
MEAN CORPUSCULAR HB CONCENTRATION	33.4	g/dL	32 - 36	
RED CELL DISTRIBUTION WIDTH	14.1	%	11.6 - 14	
TOTAL WBC COUNT	6900	cells/cumm	4000 - 11000	
NEUTROPHILS	45.1	%	35 - 77	
LYMPHOCYTES	40.6	%	21 - 44	
MONOCYTES	8.8	%	3 - 9	
EOSINOPHILS	3.7	%	0 - 3	
BASOPHILS	1.8	%	0 - 2	
ABSOLUTE NEUTROPHIL COUNT	2790	cells/cumm	2000 - 7000	
ABSOLUTE LYMPHOCYTE COUNT	2490	cells/cumm	1000 - 3000	
ABSOLUTE MONOCYTE COUNT	600	cells/cumm	200 - 1000	
ABSOLUTE EOSINOPHIL COUNT	260	cells/cumm	20 - 500	
ABSOLUTE BASOPHIL COUNT	100	cells/cumm	20 - 100	
PLATELET COUNT	1.05	lakhs/cumm	1.5 - 4.5	

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:

B. To be completed by the Claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASON FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

One timw medical test cardiology 2D echo and ECG

PATIENT NAME	GURUPRASAD SRIHARI	DATE	02-06-2025
AGE/SEX	58 YRS, MALE	PERFORMED BY	IN BS/YD
ECHO ID	20207	REF BY	CARDIOLOGY

MEASUREMENTS AND CALCULATIONS (2D, M-MODE AND DOPPLER)

LVIDd	43	cms
LVIDs	28	cms
IVSd	09	cms
IVSs	12	cms
LVPWd	09	cms
LVPWs	12	cms
RVIDd	15	cms
AO	30	cms
LA	30	cms
EDV	84	ml
ESV	30	ml
EF	63	%

ADDITIONALS		

MITRAL VALVE		
E Vmax	-	m/sec
A Vmax	-	m/sec
DecT	-	ms
IVRT	-	ms
E/A RATIO	-	
AORTIC VALVE		
AV Vmax	-	m/sec
AV PGmax	-	mmHg
PULMONARY VALVE		
PV Vmax	-	m/sec
PV PGmax	-	mmHg
TRICUSPID VALVE		
TR PG max	25	mmHg
PASP	30	mmHg

FINAL ECHOCARDIOGRAPHIC IMPRESSION

- SCLEROTIC AORTIC VALVE, TRIVIAL AR
- MILD MR
- NO RESTING REGIONAL WALL MOTION ABNORMALITIES
- NORMAL LV SYSTOLIC FUNCTION, LVEF:63%
- NO PERICARDIAL EFFUSION/CLOT/VEGETATION

***SUB-OPTIMAL STUDY ***

** KINDLY CORRELATE CLINICALLY **

DR. M. DIVYAPRAKASH
PROFESSOR AND HEAD, DEPT. OF CARDIOLOGY (UNIT I)
BMC&RI-SSH

PATIENT NAME	GURUPRASAD SRIHARI	PERFORMED BY	IN BS/YD
AGE/SEX	58 YRS, MALE	REF BY	CARDIOLOGY
ECHO ID	20207		

2D AND DOPPLER FINDINGS

RHYTHM	SINUS
SITUS	SOLITUS
SYSTEMIC AND PULMONARY VENOUS DRAINAGE	NORMAL
MITRAL VALVE	NORMAL
AORTIC VALVE	TRILEAFLETS, SCLEROTIC
TRICUSPID VALVE	NORMAL
PULMONARY VALVE	NORMAL
INTER-ATRIAL SEPTUM	INTACT
INTER-VENTRICULAR SEPTUM	INTACT
RIGHT ATRIUM	NORMAL
RIGHT VENTRICLE	NORMAL
LEFT ATRIUM	NORMAL
LEFT VENTRICLE	NORMAL IN SIZE NO RESTING RWMA NORMAL SYSTOLIC FUNCTION
AORTA	NORMAL
PULMONARY ARTERY	NORMAL
PERICARDIUM	NO EFFUSION
DOPLER STUDY	TRIVIAL AR, TR & GRADE I MR