

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 01/01/2010 and ending 12/31/2019	
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 PROBCLIENTOY10T19
1b	Three-digit plan number (PN) ▶ 072
1c	Effective date of plan 01/01/2010
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) 521990

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 ☒ 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	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) (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 01/01/2001 and ending 12/31/2020		
A Name of plan PROBCLIENTOY10T19	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.
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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 12000	(b) Total amount of fees paid 1000
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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 ORE EMBOWS LAUDS CREDE ACCEDED BASIS,RULES RILES	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) ☒ individual policies (2) ☐ group deferred annuity
(3) ☒ 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) ☒ deposit administration (2) ☐ immediate participation guarantee
(3) ☒ 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** ☒ 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) ▶ **PERFORES PHYSQ R CE MASK WHIT S NATURAL PERVASE STAT NO FRINGE**

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 ☒ 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
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2010 and ending 12/31/2019

- 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 PROBCLIENTOY10T19	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) ☒ 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) 1000
(2) Information for plans using spread gain methods:	
(a) Unfunded liability for methods with bases	1c(2)(a) 600
(b) Accrued liability under entry age normal method	1c(2)(b) 600
(c) Normal cost under entry age normal method	1c(2)(c) 700
(3) Accrued liability under unit credit cost method	1c(3) 10800
d Information on current liabilities of the plan:	
(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1) 160
(2) "RPA '94" information:	
(a) Current liability	1d(2)(a) 150
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b) 350
(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) 150

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	01/01/2010
Signature of actuary GURUPRASAD SRIHARI	Date 24-75494
Type or print name of actuary CLIENTO FINANCIAL LLC SERIES	Most recent enrollment number +919482912724
Firm name 50 W 3900 STE3 B SALT LAKE CITY, UT 84107	Telephone number (including area code)
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	10000
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	6	
(2) For terminated vested participants		
(3) For active participants:		
(a) Non-vested benefits		4000
(b) Vested benefits		3500
(c) Total active		7500
(4) Total	6	7500
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
01/01/2019	850	1200			
Totals ▶			3(b)	850	1200
(d) Total withdrawal liability amounts included in line 3(b) total					3(d)

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	4a	64.8 %
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:	4f	
• 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."		

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	☒ Yes ☐ No ☐ N/A		☒ 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 ☒ 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)		12.00 %
(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 ☒ No	
(2) Is the plan required to provide a Schedule of Active Participant Data? (See instructions).	☐ Yes ☒ 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 ☒ 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 ☒ 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	2000
b Employer's normal cost for plan year as of valuation date	9b	3200

c Amortization charges as of valuation date:**(1)** All bases except funding waivers and certain bases for which the amortization period has been extended**(2)** Funding waivers**(3)** Certain bases for which the amortization period has been extended.....

	Outstanding balance	
9c(1)	1250	1400
9c(2)		
9c(3)		

d Interest as applicable on lines 9a, 9b, and 9c.....**9d** 750**e** Total charges. Add lines 9a through 9d.....**9e** 7350**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**h** Amortization credits as of valuation date.....

	Outstanding balance	
9h	450	600

i Interest as applicable to end of plan year on lines 9f, 9g, and 9h**9i** 300**j** Full funding limitation (FFL) and credits:**(1)** ERISA FFL (accrued liability FFL).....**(2)** "RPA '94" override (90% current liability FFL)**(3)** FFL credit

9j(1)	5500
9j(2)	4600

9j(3) 2600**k (1)** Waived funding deficiency**9k(1)** 1400**(2)** Other credits**9k(2)** 600**l** Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)**9l** 6350**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** 1000**o** Current year's accumulated reconciliation account:**(1)** Due to waived funding deficiency accumulated prior to the current plan year.....**9o(1)** 200**(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)****(b)** Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))**9o(2)(b)** 0**(3)** Total as of valuation date**9o(3)** 200**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) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider 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.	OMB No. 1210-0110
		2025
		This Form is Open to Public Inspection.
For calendar plan year 2025 or fiscal plan year beginning 01/01/2010 and ending 12/31/2019		
A Name of plan PROBCLIENTOY10T19	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	Service Provider Information (see instructions)
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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	50 W 3900 STE3B SALT LAKE CITY, UT 84107
27-4300000	

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
GURUPRASAD SRIHARI	210 W SIXTH STREET APT 302 ERIE, PA 16507
38-3269858	

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
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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 ☒ No ☐	Yes ☒ No ☐	2000	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 ☐

(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
CLIENTO FINANCIAL LLC SERIES	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 27-4300000 50 W 3900 STE 3 B SALT LAKE CITY, UT 84107 US	SERVICES AS US CONGRESS, LEGAL AMENDMENTS RILED TO SENATE COUNCIL, STATE LAWS AS FORMULA STATUS PARED INDEMNITY ENTIRETY. PERSONAL CRAN S STAN CE APPROVED, ORES CHEMICAL DEPOSITS SILVER. RILINGS CEDED LAUDS HERD ACEDE EXALIFY SELF CRAN STAN CE PHYSQ	
(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.	
(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 ServiceDepartment 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 PROBCLIENTOY10T19	B Three-digit plan number (PN) ► 072
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
	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
	3d	PN
	4a Plan administrator's name and address FRANCIS P GORMAN ESTATE FRANCIS P GORMAN 142 SHERMAN ROAD ENFIELD, CT 06082	4b
	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	

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule DCG (2025)
v. 250312

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.)		X	
b	Were there any nonexempt transactions with any party-in-interest?		X	
c	Has the plan failed to provide any benefit when due under the plan?		X	
d	Was the plan covered by a fidelity bond?	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?		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
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 (MALE)
Age/sex : 38 Yr / Male
Patient No : 111
Referral No : 10-01-000000
Referral Date : 20-01-2017
Referral Time : 10:00 AM
Referral Place : 10-01-000000

TEST NAME :
UNIT :
REF. NO. :
REF. DATE :
REF. TIME :
REF. PLACE :

TEST NAME	UNIT	REF. NO.	REF. DATE	REF. TIME	REF. PLACE
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000
MR. EUBO (MALE)		111	20-01-2017	10:00 AM	10-01-000000

TESTED BY :
CHECKED BY :
REVIEWED BY :
APPROVED BY :
DATE :
TIME :
PLACE :

TESTED BY :
CHECKED BY :
REVIEWED BY :
APPROVED BY :
DATE :
TIME :
PLACE :

TESTED BY :
CHECKED BY :
REVIEWED BY :
APPROVED BY :
DATE :
TIME :
PLACE :



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	10
Method: Spectrophotometry				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

PPBS: POST PRANDIAL BLOOD SUGAR				
PPBS: POST PRANDIAL BLOOD SUGAR	123.8	mg/dL	< 140	10
Method: Spectrophotometry				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

HBA1C				
HBA1C	6.0	%	5.0 - 5.9	10
Method: HPLC - Ion Exchange				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

KIDNEY FUNCTION TEST (KFT)				
SERUM UREA	37	mg/dL	16.6 - 46.5	10
Method: Spectrophotometry				

SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9	10
Method: Jaffe's Reaction				

BIOCHEMISTRY				
Verified By			BIOCHEMISTRY	
			Certified By	

SERUM ELECTROLYTES				
SODIUM	139	mmol/L	136 - 145	10



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 : 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: Indirectly calculated				
TOTAL PROTEIN	7.5	g/dL	6.6 - 8.7	
Method: BSA				
ALBUMIN	4.8	g/dL	3.50 - 4.61	
Method: BSA				
GLOBULIN	2.7	g/dL	2.8 - 3.5	
Method: Normalized calculation				
A/G RATIO	1.8		1.5 : 1 to 2.5 : 1	
Method: Indirectly calculated				
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, standardized to serum without ethanol PLP activation				
ALP/ALP	12	U/L	Males - upto 41 Females - upto 33	
Method: JCA, standardized to serum without ethanol 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	

Mean Platelet Volume (MPV) = $\frac{\text{Hematocrit}}{\text{Hemoglobin}} \times 100$

Dr. PAVLOVA
Verified By

Dr. PAVLOVA
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	437579
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) (estimated)				
PACKED CELL VOLUME	44.3	%	40 - 50	
MCV (fL) (estimated)				
RED BLOOD CELL COUNT	4.87	cells/mm ³	4.0 - 5.5	
RETICULOCYTE COUNT (percentage) (estimated)				
MEAN CORPUSCULAR VOLUME	91.2	fL	80 - 100	
MCV (fL) (estimated)				
MEAN CORPUSCULAR HEMOGLOBIN	30.5	pg	29 - 34	
MCH (pg) (estimated)				
MEAN CORPUSCULAR Hb CONCENTRATION	33.4	g/dL	32 - 38	
MCHC (g/dL) (estimated)				
RED CELL DISTRIBUTION WIDTH	14.1	%	11.8 - 14	
RDW (CV) (estimated)				
TOTAL WBC COUNT	8900	cells/mm ³	4000 - 11000	
WBC (cells/mm ³) (estimated)				
NEUTROPHILS	45.1	%	35 - 77	
NEUT (percentage) (estimated)				
LYMPHOCYTES	40.6	%	24 - 49	
LYM (percentage) (estimated)				
MONOCYTES	8.8	%	0 - 5	
MON (percentage) (estimated)				
EOSINOPHILS	3.7	%	0 - 3	
EOS (percentage) (estimated)				
BASEOPHILS	1.0	%	0 - 2	
BASE (percentage) (estimated)				
ABSOLUTE NEUTROPHIL COUNT	2790	cells/mm ³	2000 - 7000	
NEUT (cells/mm ³) (estimated)				
ABSOLUTE LYMPHOCYTE COUNT	2400	cells/mm ³	1000 - 3000	
LYM (cells/mm ³) (estimated)				
ABSOLUTE MONOCYTE COUNT	600	cells/mm ³	200 - 1000	
MON (cells/mm ³) (estimated)				
ABSOLUTE EOSINOPHIL COUNT	280	cells/mm ³	50 - 500	
EOS (cells/mm ³) (estimated)				
ABSOLUTE BASEOPHIL COUNT	100	cells/mm ³	20 - 100	
BASE (cells/mm ³) (estimated)				
PLATELET COUNT	1.05	platelets/mm ³	1.5 - 4.5	
PLT (cells/mm ³) (estimated)				

