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 01/01/1991 and ending 12/31/2024

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.)
- [X] a single-employer plan
- [ ] a DFE (specify) _____

B This return/report is:
- [X] 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:
- [X] 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
PROBUSKSLMAN

1b Three-digit plan number (PN) ▶ 050

1c Effective date of plan 01/01/2015

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
KALMAN HUJTER TR FIM
FIRST VALLEY BANK
836, 16TH MAIN ROAD BANASHANKARI 2 STAGE
BENGALURU, KARNATAKA 560070 IN

160 BRODHEAD RD
BETHLEHELM, PA 18017

2b Employer Identification Number (EIN)
23-7682545

2c Plan Sponsor's telephone number
+919482912724

2d Business code (see instructions)
522110

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.	05/21/2026	GURUPRASAD SRIHARI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	05/21/2026	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:

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	6
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	4
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	4
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**	4
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	4
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)**	4
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**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

3B 1G 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

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [X] 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)** [X] 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)** [X] **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)** [X] **A** (Insurance Information) – Number Attached 2
- **(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

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

A Name of plan
PROBUSKSLMAN

B Three-digit plan number (PN) ▶ 050

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

D Employer Identification Number (EIN)
23-7682545

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
FIRST VALLEY BANK

(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
23-7682545	52211	194102900	6	01/01/2009	12/31/2025

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
1200	400

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

GURUPRASAD SRIHARI
210 W SIXTH STREET
APT 302
ERIE, PA 16507

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1000	100	WARREN ALPERT MEDICAL SCHOOL COMPOSITE MEDICAL SCIENCE & PARTICULARLY NEUROSCIENCE. WH F WRT CRN. LGLCN	5

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	4500
5	Current value of plan's interest under this contract in separate accounts at year end	5	500

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ RESEARCH NSCNCE WRT STNC

b	Premiums paid to carrier	6b	
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	

Specify nature of costs ▶

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

(3) [ ] other (specify) ▶

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) [X] immediate participation guarantee

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

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)	1400		
	(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)	1400
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	1400
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)	600		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	600
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	800

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** [X] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [X] Other (specify) ▶ PHYSCIAN MEDICAL BASIC

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(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)	
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)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(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 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 01/01/2025 and ending 12/31/2025

A Name of plan
PROBUSKSLMAN

B Three-digit plan number (PN) ▶ 050

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

D Employer Identification Number (EIN)
23-7682545

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
YOUNG FAMILY IRRV LIFE INS TR

(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
38-3269858	00533	6 O71 I 239960	6	01/01/2009	12/31/2025

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
800	400

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

GURUPRASAD SRIHARI
210 W SIXTH STREET
APT 302
ERIE, PA 16507

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
400	250	SPOUSAL WRT WHF	4

(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	600
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
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	

Specify nature of costs ▶

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

(3) [ ] other (specify) ▶

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) [X] immediate participation guarantee

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

b	Balance at the end of the previous year			7b	
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)	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(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)	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

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** [ ] 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** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)	350		
(2) Increase (decrease) in amount due but unpaid	9a(2)	200		
(3) Increase (decrease) in unearned premium reserve	9a(3)	250		
(4) Earned ((1) + (2) - (3))			9a(4)	300
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)	400		
(B) Administrative service or other fees	9c(1)(B)	250		
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)	200		
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	850
(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 R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2025

This Form is Open to Public Inspection.

For calendar plan year 2025 or fiscal plan year beginning 01/01/1991 and ending 12/31/2024

A Name of plan
PROBUSKSLMAN

B Three-digit plan number (PN) ▶ 050

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

D Employer Identification Number (EIN)
23-7682545

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions ..... | **1** |

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): _____ _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year ..... | **3** | 2

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☒ **Yes** ☐ **No** ☐ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) ..... | **6a** |

b Enter the amount contributed by the employer to the plan for this plan year ..... | **6b** |

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) ..... | **6c** |

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. ..... ☐ **Increase** ☐ **Decrease** ☐ **Both** ☒ **No**

Part IV ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☒ **No**

11 **a** Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☒ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☒ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☒ **No**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ______________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ______________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ______________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ______________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ______________________________

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ last contributing employer ☒ alternative ☐ reasonable approximation (see instructions for required attachment)	**14a**	2
b The plan year immediately preceding the current plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14b**	
c The second preceding plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14c**	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%
High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
☐ 0-5 years ☐ 5-10 years ☐ 10-15 years ☐ 15 years or more

20 **PBGC missed contribution reporting requirements.** If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? ☐ Yes ☐ No

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

☐ Yes.

☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

☐ No. Other. Provide explanation._____

Part VII IRS Compliance Questions

21a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? ☐ Yes ☒ No

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

☒ Design-based safe harbor method

☐ "Prior year" ADP test

☐ "Current year" ADP test

☐ N/A

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/_____ (MM/DD/YYYY) and the Opinion Letter serial number_____.

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

Dr. PHILOMIN
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 ***

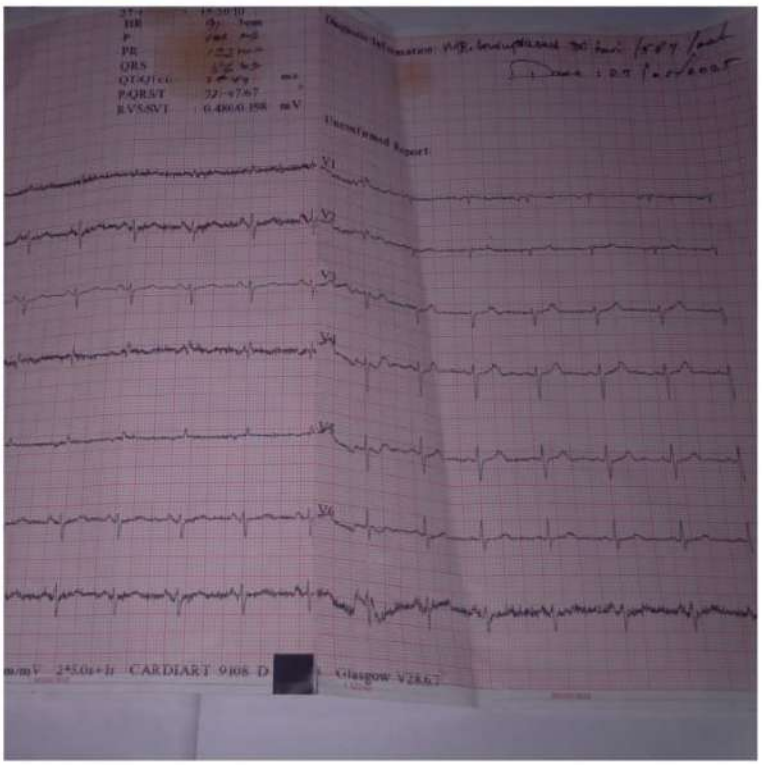
** KINDLY CORRELATE CLINICALLY **

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



Landowner Report Summary

Notification #2302572

General Details

LOR Reporting Year:
2023

Town, Township, or Plantation:
Wayne

County:
Kennebec

Landowner Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

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

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

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

Method of Payment or Type of Sale:
This harvest was conducted under a contract for logging service (CLS)

Involvement Details

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

Operator/Harvester Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

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

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

Broker(s)/Exporter(s)

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

Activity Details

Harvest Information

Partial cut:
0 acres

Initial/Intermediate Shelterwood Harvest:
0 acres

Final/Overstory Removal Shelterwood Harvest:
0 acres

Clear Cut Harvest(s):

1. 2 acres

Change of Land Use

2 acres

Non-Harvest Information

Herbicide Treatment:

Site Preparation:
1 acres

Release Acres:
1 acres

Non-Commercial Thinning:
1 acres

Tree Planting:

1. : 2 acres

Additional Information:
Saplings

Stumpage Details

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

Standard Products

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

Specialty Products

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