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 01/01/2025 and ending 12/31/2025

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:
- [ ] 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
- [ ] 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
OBHG 401(K) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 02/01/2011

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)
OBHG MANAGEMENT SERVICES, LLC

OB HOSPITALIST GROUP
GREENVILLE, SC 29607

2b Employer Identification Number (EIN)
80-0950275

2c Plan Sponsor's telephone number
864-908-3603

2d Business code (see instructions)
621498

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.	10/15/2026	JACQUELINE LEBRON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**3b**	Administrator's EIN
		3c	Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	2715
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)**	2566
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	2856
b	Retired or separated participants receiving benefits	**6b**	5
c	Other retired or separated participants entitled to future benefits	**6c**	144
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	3005
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f	Total. Add lines **6d** and **6e**.	**6f**	3005
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)**	1179
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)**	1305
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	21
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:

2E 2F 2G 2J 2K 2T 3D 2A

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

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

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **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
OBHG 401(K) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
OBHG MANAGEMENT SERVICES, LLC

D Employer Identification Number (EIN)
80-0950275

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
VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY

(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
71-0294708	86509	DH3137	3005	01/01/2025	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
2567	0

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

KESTRA INVESTMENT SERVICES, LLC
STE 400 5707 SOUTHWEST PKWY BLDG 2
AUSTIN, TX 78735

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2567			3

(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	4693517
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) ☐ 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) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP PENSION FUNDING

b	Balance at the end of the previous year			7b	4286549
c	Additions: (1) Contributions deposited during the year	7c(1)	1545991		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	71789		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)	233024		
	▶ *				
	(6)Total additions			7c(6)	1850804
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	6137353
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1197824		
	(2) Administration charge made by carrier	7e(2)	20502		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)	26624		
	▶ *				
	(5) Total deductions			7e(5)	1244950
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	4892403

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(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 ☒ No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2025** **This Form is Open to Public Inspection.**

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

A Name of plan
OBHG 401(K) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
OBHG MANAGEMENT SERVICES, LLC

D Employer Identification Number (EIN)
80-0950275

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

VOYA RETIREMENT INSURANCE & ANNUITY

71-0294708

(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)

VOYA RETIREMENT INSURANCE & ANNUITY

71-0294708

(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?
64	RECORD KEEPER	291694	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

VOYA RETIREMENT ADVISORS, LLC

02-0488491

(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?
26	SERVICE PROVIDER	77912	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

RSM US LLP

42-0714325

(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?
99	SERVICE PROVIDER	22522	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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)

OB HOSPITALIST GROUP LLC

80-0950275

(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?
99	SERVICE PROVIDER	9234	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

KESTRA INVESTMENT SERVICES, LLC

06-1375177

(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?
55	BROKER/DEALER	0	Yes [X] No [ ]	Yes [ ] No [X]	67136	Yes [ ] No [X]

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

KESTRA ADVISORY SERVICES LLC

35-2552359

(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?
99	SERVICE PROVIDER	0	Yes [X] No [ ]	Yes [ ] No [X]	42003	Yes [ ] No [X]

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
KESTRA ADVISORY SERVICES LLC	99	42003
(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.	
VOYA RETIREMENT INSURANCE & ANNUITY 71-0294708	OTHER FEES	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
KESTRA INVESTMENT SERVICES, LLC	55	67136
(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.	
VOYA RETIREMENT INSURANCE & ANNUITY 71-0294708	OTHER COMMISSIONS	

(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

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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 D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan 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 01/01/2025 and ending 12/31/2025

A Name of plan
OBHG 401(K) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
OBHG MANAGEMENT SERVICES, LLC

D Employer Identification Number (EIN)
80-0950275

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TRUST T. ROWE PRICE RET DATE 200

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289829-001	C	89680

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2010 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289830-001	C	757112

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2015 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289831-001	C	2011463

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2020 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289832-001	C	2029420

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2025 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289833-001	C	4089404

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2030 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289834-001	C	9557837

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2035 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
38-7289835-001	C	9396180

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2040 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289836-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 8114399

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2045 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289837-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 7011868

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2050 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289838-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 5757455

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2055 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289839-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1492953

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2060 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289840-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 509736

a Name of MTIA, CCT, PSA, or 103-12 IE: GG TR TROWEPRC RET DATE 2065 TR R1

b Name of sponsor of entity listed in (a): GREAT GRAY TRUST COMPANY, LLC

c EIN-PN 38-7289841-001	**d** Entity code C	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 806218

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
OBHG 401(K) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
OBHG MANAGEMENT SERVICES, LLC

D Employer Identification Number (EIN)
80-0950275

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	687331	544218
(9) Value of interest in common/collective trusts	1c(9)	42469553	51623726
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	65865296	80112867
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	4286549	4892403
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	113308729	137173214
Liabilities			
1g Benefit claims payable	1g		
1h Operating payables	1h		
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	113308729	137173214

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	2521392	
(B) Participants	2a(1)(B)	18662967	
(C) Others (including rollovers)	2a(1)(C)	5286022	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		26470381
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	59492	
(F) Other	2b(1)(F)	71789	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		131281
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	3144218	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		3144218
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		7413559
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		8302585
c Other income	2c		28277
d Total income. Add all **income** amounts in column (b) and enter total	2d		45490301
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	21152983	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		21152983
f Corrective distributions (see instructions)	2f		8560
g Certain deemed distributions of participant loans (see instructions)	2g		62911
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	284816	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	87357	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	29189	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		401362
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		21625816
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		23864485
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] 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) [X] 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: RSM US LLP **(2)** EIN: 42-0714325

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**	X		96300
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		3000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**	X		
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection.

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

A Name of plan
OBHG 401(K) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
OBHG MANAGEMENT SERVICES, LLC

D Employer Identification Number (EIN)
80-0950275

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): 71-0294708

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

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**	
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 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q702844A .

Ob Hospitalist GROUP

October 15, 2026

To Whom It May Concern,

Plan name: OBHG 401(k) Plan
Federal employer identification number: 80-0950275
Plan number: 002
For the plan year ended: 2025

Form 5500, Schedule H, Part III, Accountant's Opinion

Due to unexpected delays in compiling the necessary information, audited financial statements are not yet available. We are filing Form 5500 without the required statements to ensure timely filing. Upon completion of the audit, we will promptly amend Form 5500 to include all required information.

Sincerely,

Cheryl Slack

Cheryl Slack
Chief Human Resources Officer
Plan Sponsor

Form **5330**
(Rev. December 2022)
Department of the Treasury
Internal Revenue Service

Return of Excise Taxes Related to Employee Benefit Plans

(under sections 4965, 4971, 4972, 4973(a)(3), 4975, 4976, 4977, 4978, 4979, 4979A, 4980, and 4980F of the Internal Revenue Code)

Go to *www.irs.gov/Form5330* for instructions and the latest information.

OMB No. 1545-0575

Filer tax year beginning **January 1, 2023** , and ending **December 31, 2023** ,

A Name of filer (see instructions)
OBHG Management Services, LLC

Number, street, and room or suite no. (If a P.O. box or foreign address, see instructions.)
77 Lowndes Hill Road, Building #1

City or town, state or province, country, and ZIP or foreign postal code
Greenville, SC 29607

B Filer's identifying number (Enter either the EIN or SSN, but not both. See instructions.)
Employer identification number (EIN)
80-0950275
Social security number (SSN)

C Name of plan
OBHG 401(k) Plan

D Name and address of plan sponsor
Same as above

E Plan sponsor's EIN
80-0950275

F Plan year ending (MM/DD/YYYY)
12/31/2023

H If this is an **amended return**, check here ☐

G Plan number
002

Part I Taxes. You can only complete one section of Part I for each Form 5330 filed. See instructions.

Section A. Taxes that are reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

	FOR IRS USE ONLY		
1 Section 4972 tax on nondeductible contributions to qualified plans (from Schedule A, line 12)	161	1	
2 Section 4973(a)(3) tax on excess contributions to section 403(b)(7)(A) custodial accounts (from Schedule B, line 12)	164	2	
3 a Section 4975(a) tax on prohibited transactions (from Schedule C, line 3)	159	3a	$19.74
b Section 4975(b) tax on failure to correct prohibited transactions	224	3b	
4 Section 4976 tax on disqualified benefits for funded welfare plans	200	4	
5 a Section 4978 tax on ESOP dispositions	209	5a	
b The tax on line 5a is a result of the application of: ☐ Sec. 664(g) ☐ Sec. 1042		5b	
6 Section 4979A tax on certain prohibited allocations of qualified ESOP securities or ownership of synthetic equity	203	6	
7 **Total Section A taxes.** Add lines 1 through 6. Enter here and on Part II, line 17		7	$19.74

Section B. Taxes that are reported by the 15th day of the 10th month after the last day of the plan year

8 a Section 4971(a) tax on failure to meet minimum funding standards (from Schedule D, line 2)	163	8a
b Section 4971(b) tax for failure to correct minimum funding standards	225	8b
9 a Section 4971(f)(1) tax on failure to pay liquidity shortfall (from Schedule E, line 4)	226	9a
b Section 4971(f)(2) tax for failure to correct liquidity shortfall	227	9b
10 a Section 4971(g)(2) tax on failure to comply with a funding improvement or rehabilitation plan (see instructions)	450	10a
b Section 4971(g)(3) tax on failure to meet requirements for plans in endangered or critical status (from Schedule F, line 1c)	451	10b
c Section 4971(g)(4) tax on failure to adopt rehabilitation plan (from Schedule F, line 2d)	452	10c
d Section 4971(h) tax on failure of a CSEC plan sponsor to adopt funding restoration plan (from Schedule L, line 2)	453	10d

Section B1. Tax that is reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees

11 Section 4977 tax on excess fringe benefits (from Schedule G, line 4)	201	11
12 **Total Section B taxes.** Add lines 8a through 10d or 11. Enter here and on Part II, line 17		12

Section C. Tax that is reported by the last day of the 15th month after the end of the plan year

13 Section 4979 tax on excess contributions to certain plans (from Schedule H, line 2). Enter here and on Part II, line 17	205	13

Name of filer: OBHG Management Services, LLC Filer's identifying number:80-0950275

Section D. Tax that is reported by the last day of the month following the month in which the reversion occurred

14 Section 4980 tax on reversion of qualified plan assets to an employer (from Schedule I, line 3). Enter here and on Part II, line 17 204 **14**

Section E. Tax that is reported by the last day of the month following the month in which the failure occurred

15 Section 4980F tax on failure to provide notice of significant reduction in future accruals (from Schedule J, line 5). Enter here and on Part II, line 17 228 **15**

Section F. Taxes reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

16 Section 4965 tax on prohibited tax shelter transactions for entity managers (from Schedule K, line 2). Enter here and on Part II, line 17 237 **16**

Part II Tax Due

17	Enter the amount from Part I, line 7, 12, 13, 14, 15, or 16 (whichever is applicable)	**17**	**$19.74**
18	Enter the amount of tax paid with Form 5558 or any other tax paid prior to filing this return	**18**	
19	**Tax due.** Subtract line 18 from line 17. If the result is greater than zero, enter here	**19**	**$19.74**

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature: Cheryl Slack Telephone number: 864-516-2226 Date: 10-15-2

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
Firm's name			Firm's EIN	
Firm's address			Phone no.	

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule A. Tax on Nondeductible Employer Contributions to Qualified Employer Plans (Section 4972) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total contributions for your tax year to your qualified employer plan (under section 401(a), 403(a), 408(k), or 408(p))		1
2	Amount allowable as a deduction under section 404		2
3	Subtract line 2 from line 1		3
4	Enter amount of any prior year nondeductible contributions made for years beginning after 12/31/86	4	
5	Amount of any prior year nondeductible contributions for years beginning after 12/31/86 returned to you in this tax year for any prior tax year	5	
6	Subtract line 5 from line 4	6	
7	Amount of line 6 carried forward and deductible in this tax year	7	
8	Subtract line 7 from line 6		8
9	Tentative taxable excess contributions. Add lines 3 and 8		9
10	Nondeductible section 4972(c)(6) or (7) contributions exempt from excise tax		10
11	Taxable excess contributions. Subtract line 10 from line 9		11
12	Multiply line 11 by 10%. Enter here and on Part I, line 1		12

Schedule B. Tax on Excess Contributions to Section 403(b)(7)(A) Custodial Accounts (Section 4973(a)(3)) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total amount contributed for current year less rollovers. See instructions	1
2	Amount excludable from gross income under section 403(b). See instructions	2
4	Prior year excess contributions not previously eliminated. If zero, go to line 8	4
6	Total of all prior years' distributions out of the account included in your gross income under section 72(e) and not previously used to reduce excess contributions	6
7	Adjusted prior years' excess contributions. Subtract the total of lines 5 and 6 from line 4	7
8	Taxable excess contributions. Add lines 3 and 7	8
9	Multiply line 8 by 6%	9
10	Enter the value of your account as of the last day of the year	10
11	Multiply line 10 by 6%	11
12	**Excess contributions tax.** Enter the lesser of line 9 or line 11 here and on Part I, line 2	12

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule C. Tax on Prohibited Transactions (Section 4975) (*see instructions*) **Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)**

1 Is the excise tax a result of a prohibited transaction that was (box "a" or box "b" must be checked):

a ~~discrete~~ **b X** ~~other than discrete (a lease or a loan)~~

2 Complete the table below to disclose the prohibited transactions and figure the initial tax. See instructions.

(a) Transaction number	(b) Date of transaction (see instructions)	(c) Description of prohibited transaction	(d) Amount involved in prohibited transaction (see instructions)	(e) Initial tax on prohibited transaction (multiply each transaction in column (d) by the appropriate rate (see instructions))
(i)	**1/13/2023**	**Late deposit of deferrals/loan payments**	**$129.97**	**$19.50**
(ii)	**1/20/2023**	**Late deposit of deferrals/loan payments**	**$.69**	**$.10**
(iii)	**5/5/2023**	**Late deposit of deferrals/loan payments**	**$.24**	**$.04**
(iv)	**10/6/2023**	**Late deposit of deferrals/loan payments**	**$.68**	**$.10**
(v)				
(vi)				
(vii)				
(viii)				
(ix)				
(x)				
(xi)				
(xii)				

3 Add amounts in column (e); enter here and on Part I, line 3a **3** **$19.74**

4 Have you corrected all of the prohibited transactions that you are reporting on this return? If "Yes," complete Schedule C, line 5, on the next page. If "No," attach statement. See instructions ✓**Yes** ..... **No**

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule C. Tax on Prohibited Transactions (Section 4975) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return) (*continued*)

5 Complete the table below, if applicable, of other participating disqualified persons and description of correction. See instructions.

(a) Item no. from line 2	(b) Name and address of disqualified person	(c) EIN or SSN	(d) Date of correction	(e) Description of correction
(i)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	8/23/2023	Deposit late contributions/payments
(ii)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	2/1/2023	Deposit late contributions/payments
(iii)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	5/12/2023	Deposit late contributions/payments
(iv)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	10/13/2023	Deposit late contributions/payments

Schedule D. Tax on Failure To Meet Minimum Funding Standards (Section 4971(a)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Aggregate unpaid required contributions (accumulated funding deficiency for multiemployer plans). See instructions	**1**
2	Multiply line 1 by 10% (5% for multiemployer plans). Enter here and on Part I, line 8a	**2**

Schedule E. Tax on Failure To Pay Liquidity Shortfall (Section 4971(f)(1)) Reported by the 15th day of the 10th month after the last day of the plan year

			(a) 1st Quarter	(b) 2nd Quarter	(c) 3rd Quarter	(d) 4th Quarter	(e) Total (add cols. a–d for line 3)
1	Amount of shortfall	1					
2	Shortfall paid by the due date	2					
3	Net shortfall amount	3					
4	Multiply line 3, column (e), by 10%. Enter here and on Part I, line 9a	4					

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule F. Tax on Multiemployer Plans in Endangered or Critical Status (Sections 4971(g)(3) and 4971(g)(4)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Section 4971(g)(3) tax on failure to meet requirements for plans in endangered or critical status.	
a	Enter the amount of contributions necessary to meet the applicable benchmarks or requirements . .	1a
b	Enter the amount of the accumulated funding deficiency	1b
c	Multiply the greater of line 1a or line 1b by 5%. Enter the result here and on Part I, line 10b	1c
2	Section 4971(g)(4) tax on failure to adopt rehabilitation plan.	
a	Enter the amount of the excise tax on the accumulated funding deficiency under section 4971(a)(2) from Schedule D, line 2	2a
b	Enter the number of days during the tax year which are included in the period beginning on the first day following the close of the 240-day period and ending on the day the rehabilitation plan is adopted	
c	Multiply line 2b by $1,100	2c
d	Enter the greater of line 2a or line 2c here and on Part I, line 10c	2d

Schedule G. Tax on Excess Fringe Benefits (Section 4977) Reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees

1	Did you make an election to be taxed under section 4977? **Yes** **No**	
2	If "Yes," enter the calendar year (YYYY) in which the excess fringe benefits were paid: _____	
3	If line 1 is "Yes," enter the excess fringe benefits on this line. See instructions	3
4	Enter 30% of line 3 here and on Part I, line 11	4

Schedule H. Tax on Excess Contributions to Certain Plans (Section 4979) Reported by the last day of the 15th month after the end of the plan year

1	Enter the amount of an excess contribution under a cash or deferred arrangement that is part of a plan qualified under section 401(a), 403(a), 403(b), 408(k), or 501(c)(18) or excess aggregate contributions.	1
2	Multiply line 1 by 10% and enter here and on Part I, line 13	2

Schedule I. Tax on Reversion of Qualified Plan Assets to an Employer (Section 4980) Reported by the last day of the month following the month in which the reversion occurred

1	Date reversion occurred MM _____ DD _____ YY _____	
2 a	Employer reversion amount: _____ **b** Excise tax rate (20% or 50%): _____	
3	Multiply line 2a by line 2b and enter the amount here and on Part I, line 14	3
4	Explain below why you qualify for a 20% rather than a 50% excise tax rate:	

Schedule J. Tax on Failure To Provide Notice of Significant Reduction in Future Accruals (Section 4980F) Reported by the last day of the month following the month in which the failure occurred

1	Enter the number of applicable individuals who were not provided ERISA section 204(h) notice:	
2	Enter the effective date of the amendment MM DD YY	
3	Enter the number of days in the noncompliance period:	
4	Enter the total number of failures to provide ERISA section 204(h) notice. See instructions	4
5	Multiply line 4 by $100. Enter here and on Part I, line 15	5
6	Provide a brief description of the failure, and of the correction, if any:	

Schedule K. Tax on Prohibited Tax Shelter Transactions (Section 4965) Reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

1	Enter the number of prohibited tax shelter transactions you caused the same plan to be a party to: _____	
2	Multiply line 1 by $20,000. Enter the result here and on Part I, line 16	2

Schedule L. Tax on Failure of a CSEC Plan Sponsor To Adopt Funding Restoration Plan (Section 4971(h)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Enter the number of days during the tax year which are included in the period beginning on the day following the close of the 180-day period described in section 433(j)(3) and ending on the day on which the funding restoration plan is adopted	2
2	Multiply line 1 by $100. Enter the result here and on Part I, line 10d	

Form **5330**
(Rev. December 2022)
Department of the Treasury
Internal Revenue Service

Return of Excise Taxes Related to Employee Benefit Plans

(under sections 4965, 4971, 4972, 4973(a)(3), 4975, 4976, 4977, 4978, 4979, 4979A, 4980, and 4980F of the Internal Revenue Code)

Go to *www.irs.gov/Form5330* for instructions and the latest information.

OMB No. 1545-0575

Filer tax year beginning **January 1, 2022** , and ending **December 31, 2022** ,

A Name of filer (see instructions)
OBHG Management Services, LLC

Number, street, and room or suite no. (If a P.O. box or foreign address, see instructions.)
77 Lowndes Hill Road, Building #1

City or town, state or province, country, and ZIP or foreign postal code
Greenville, SC 29607

B Filer's identifying number (Enter either the EIN or SSN, but not both. See instructions.)
Employer identification number (EIN)
80-0950275
Social security number (SSN)

C Name of plan
OBHG 401(k) Plan

D Name and address of plan sponsor
Same as above

E Plan sponsor's EIN
80-0950275

F Plan year ending (MM/DD/YYYY)
12/31/2022

H If this is an **amended return**, check here ☐

G Plan number
002

Part I Taxes. You can only complete one section of Part I for each Form 5330 filed. See instructions.

Section A. Taxes that are reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

		FOR IRS USE ONLY		
1	Section 4972 tax on nondeductible contributions to qualified plans (from Schedule A, line 12)	161	1	
2	Section 4973(a)(3) tax on excess contributions to section 403(b)(7)(A) custodial accounts (from Schedule B, line 12)	164	2	
3 a	Section 4975(a) tax on prohibited transactions (from Schedule C, line 3)	159	3a	$19.16
b	Section 4975(b) tax on failure to correct prohibited transactions	224	3b	
4	Section 4976 tax on disqualified benefits for funded welfare plans	200	4	
5 a	Section 4978 tax on ESOP dispositions	209	5a	
b	The tax on line 5a is a result of the application of: ☐ Sec. 664(g) ☐ Sec. 1042		5b	
6	Section 4979A tax on certain prohibited allocations of qualified ESOP securities or ownership of synthetic equity	203	6	
7	**Total Section A taxes.** Add lines 1 through 6. Enter here and on Part II, line 17		7	$19.16

Section B. Taxes that are reported by the 15th day of the 10th month after the last day of the plan year

8 a	Section 4971(a) tax on failure to meet minimum funding standards (from Schedule D, line 2)	163	8a
b	Section 4971(b) tax for failure to correct minimum funding standards	225	8b
9 a	Section 4971(f)(1) tax on failure to pay liquidity shortfall (from Schedule E, line 4)	226	9a
b	Section 4971(f)(2) tax for failure to correct liquidity shortfall	227	9b
10 a	Section 4971(g)(2) tax on failure to comply with a funding improvement or rehabilitation plan (see instructions)	450	10a
b	Section 4971(g)(3) tax on failure to meet requirements for plans in endangered or critical status (from Schedule F, line 1c)	451	10b
c	Section 4971(g)(4) tax on failure to adopt rehabilitation plan (from Schedule F, line 2d)	452	10c
d	Section 4971(h) tax on failure of a CSEC plan sponsor to adopt funding restoration plan (from Schedule L, line 2)	453	10d

Section B1. Tax that is reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees

11	Section 4977 tax on excess fringe benefits (from Schedule G, line 4)	201	11
12	**Total Section B taxes.** Add lines 8a through 10d or 11. Enter here and on Part II, line 17		12

Section C. Tax that is reported by the last day of the 15th month after the end of the plan year

13	Section 4979 tax on excess contributions to certain plans (from Schedule H, line 2). Enter here and on Part II, line 17	205	13

Name of filer: OBHG Management Services, LLC Filer's identifying number: 80-0950275

Section D. Tax that is reported by the last day of the month following the month in which the reversion occurred

14 Section 4980 tax on reversion of qualified plan assets to an employer (from Schedule I, line 3). Enter here and on Part II, line 17 204 **14**

Section E. Tax that is reported by the last day of the month following the month in which the failure occurred

15 Section 4980F tax on failure to provide notice of significant reduction in future accruals (from Schedule J, line 5). Enter here and on Part II, line 17 228 **15**

Section F. Taxes reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

16 Section 4965 tax on prohibited tax shelter transactions for entity managers (from Schedule K, line 2). Enter here and on Part II, line 17 237 **16**

Part II Tax Due

17	Enter the amount from Part I, line 7, 12, 13, 14, 15, or 16 (whichever is applicable)	**17**	**$19.16**
18	Enter the amount of tax paid with Form 5558 or any other tax paid prior to filing this return	**18**	
19	**Tax due.** Subtract line 18 from line 17. If the result is greater than zero, enter here	**19**	**$19.16**

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Cheryl Slack — Your signature

864-516-2226 — Telephone number

10-15-2023 — Date

Paid Preparer Use Only

Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN

Firm's name | Firm's EIN

Firm's address | Phone no.

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule A. Tax on Nondeductible Employer Contributions to Qualified Employer Plans (Section 4972) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total contributions for your tax year to your qualified employer plan (under section 401(a), 403(a), 408(k), or 408(p))		1
2	Amount allowable as a deduction under section 404		2
3	Subtract line 2 from line 1		3
4	Enter amount of any prior year nondeductible contributions made for years beginning after 12/31/86	4	
5	Amount of any prior year nondeductible contributions for years beginning after 12/31/86 returned to you in this tax year for any prior tax year	5	
6	Subtract line 5 from line 4	6	
7	Amount of line 6 carried forward and deductible in this tax year	7	
8	Subtract line 7 from line 6		8
9	Tentative taxable excess contributions. Add lines 3 and 8		9
10	Nondeductible section 4972(c)(6) or (7) contributions exempt from excise tax		10
11	Taxable excess contributions. Subtract line 10 from line 9		11
12	Multiply line 11 by 10%. Enter here and on Part I, line 1		12

Schedule B. Tax on Excess Contributions to Section 403(b)(7)(A) Custodial Accounts (Section 4973(a)(3)) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)

1	Total amount contributed for current year less rollovers. See instructions	1
2	Amount excludable from gross income under section 403(b). See instructions	2
4	Prior year excess contributions not previously eliminated. If zero, go to line 8	4
6	Total of all prior years' distributions out of the account included in your gross income under section 72(e) and not previously used to reduce excess contributions	6
7	Adjusted prior years' excess contributions. Subtract the total of lines 5 and 6 from line 4	7
8	Taxable excess contributions. Add lines 3 and 7	8
9	Multiply line 8 by 6%	9
10	Enter the value of your account as of the last day of the year	10
11	Multiply line 10 by 6%	11
12	**Excess contributions tax.** Enter the lesser of line 9 or line 11 here and on Part I, line 2	12

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule C. Tax on Prohibited Transactions (Section 4975) (*see instructions*) **Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return)**

1 Is the excise tax a result of a prohibited transaction that was (box "a" or box "b" must be checked):

a discrete **b X** other than discrete (a lease or a loan)

2 Complete the table below to disclose the prohibited transactions and figure the initial tax. See instructions.

(a) Transaction number	(b) Date of transaction (see instructions)	(c) Description of prohibited transaction	(d) Amount involved in prohibited transaction (see instructions)	(e) Initial tax on prohibited transaction (multiply each transaction in column (d) by the appropriate rate (see instructions))
(i)	**1/28/2022**	**Late deposit of deferrals/loan payments**	**$3.68**	**$.55**
(ii)	**2/4/2022**	**Late deposit of deferrals/loan payments**	**$48.43**	**$7.26**
(iii)	**2/11/2022**	**Late deposit of deferrals/loan payments**	**$.68**	**$.10**
(iv)	**3/8/2022**	**Late deposit of deferrals/loan payments**	**$.02**	**$.00**
(v)	**6/10/2022**	**Late deposit of deferrals/loan payments**	**$40.84**	**$6.13**
(vi)	**6/24/2022**	**Late deposit of deferrals/loan payments**	**$2.90**	**$.44**
(vii)	**11/10/2022**	**Late deposit of deferrals/loan payments**	**$31.15**	**$4.67**
(viii)				
(ix)				
(x)				
(xi)				
(xii)				

3 Add amounts in column (e); enter here and on Part I, line 3a **3** **$19.16**

4 Have you corrected all of the prohibited transactions that you are reporting on this return? If "Yes," complete Schedule C, line 5, on the next page. If "No," attach statement. See instructions ✓**Yes** ..... **No**

Name of filer: **OBHG Management Services, LLC** Filer's identifying number: **80-0950275**

Schedule C. Tax on Prohibited Transactions (Section 4975) Reported by the last day of the 7th month after the end of the tax year of the employer (or other person who must file the return) (*continued*)

5 Complete the table below, if applicable, of other participating disqualified persons and description of correction. See instructions.

(a) Item no. from line 2	(b) Name and address of disqualified person	(c) EIN or SSN	(d) Date of correction	(e) Description of correction
(i)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	2/15/2022	[redacted] Deposit late contributions/payments
(ii)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	2/11/2022	Deposit late contributions/payments
(iii)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	2/15/2022	[redacted] Deposit late contributions/payments
(iv)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	3/17/2022	[redacted] Deposit late contributions/payments
(v)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	12/12/2022	[redacted] Deposit late contributions/payments
(vi)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	7/7/2022	Deposit late contributions/payments
(vii)	OBHG Management Svcs, LLC 77 Lowndes Hill Road, Bldg #1 Greenville, SC 29607	80-0950275	11/17/2022	Deposit late contributions/payments [redacted]
	[redacted]			[redacted]
	[redacted]			[redacted]
	[redacted]			[redacted]
	[redacted]			[redacted]
	[redacted]			[redacted]

Schedule D. Tax on Failure To Meet Minimum Funding Standards (Section 4971(a)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Aggregate unpaid required contributions (accumulated funding deficiency for multiemployer plans). See instructions	1
2	Multiply line 1 by 10% (5% for multiemployer plans). Enter here and on Part I, line 8a	2

Schedule E. Tax on Failure To Pay Liquidity Shortfall (Section 4971(f)(1)) Reported by the 15th day of the 10th month after the last day of the plan year

		(a) 1st Quarter	(b) 2nd Quarter	(c) 3rd Quarter	(d) 4th Quarter	(e) Total (add cols. (a) through (d))
1 Amount of shortfall	1					
2 Shortfall paid by the due date	2					
3 Net shortfall amount	3					
4 Multiply line 3, column (e), by 10%. Enter here and on Part I, line 9a						4

Name of filer: OBHG Management Services, LLC Filer's identifying number: 80-0950275

Schedule F. Tax on Multiemployer Plans in Endangered or Critical Status (Sections 4971(g)(3) and 4971(g)(4)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Section 4971(g)(3) tax on failure to meet requirements for plans in endangered or critical status.	
a	Enter the amount of contributions necessary to meet the applicable benchmarks or requirements . .	1a
b	Enter the amount of the accumulated funding deficiency	1b
c	Multiply the greater of line 1a or line 1b by 5%. Enter the result here and on Part I, line 10b	1c
2	Section 4971(g)(4) tax on failure to adopt rehabilitation plan.	
a	Enter the amount of the excise tax on the accumulated funding deficiency under section 4971(a)(2) from Schedule D, line 2	2a
b	Enter the number of days during the tax year which are included in the period beginning on the first day following the close of the 240-day period and ending on the day the rehabilitation plan is adopted	
c	Multiply line 2b by $1,100	2c
d	Enter the greater of line 2a or line 2c here and on Part I, line 10c	2d

Schedule G. Tax on Excess Fringe Benefits (Section 4977) Reported by the last day of the 7th month after the end of the calendar year in which the excess fringe benefits were paid to the employer's employees

1	Did you make an election to be taxed under section 4977? **Yes** **No**	
2	If "Yes," enter the calendar year (YYYY) in which the excess fringe benefits were paid: _____	
3	If line 1 is "Yes," enter the excess fringe benefits on this line. See instructions	3
4	Enter 30% of line 3 here and on Part I, line 11	4

Schedule H. Tax on Excess Contributions to Certain Plans (Section 4979) Reported by the last day of the 15th month after the end of the plan year

1	Enter the amount of an excess contribution under a cash or deferred arrangement that is part of a plan qualified under section 401(a), 403(a), 403(b), 408(k), or 501(c)(18) or excess aggregate contributions.	1
2	Multiply line 1 by 10% and enter here and on Part I, line 13	2

Schedule I. Tax on Reversion of Qualified Plan Assets to an Employer (Section 4980) Reported by the last day of the month following the month in which the reversion occurred

1	Date reversion occurred MM _____ DD _____ YY _____	
2 a	Employer reversion amount: _____ **b** Excise tax rate (20% or 50%): _____	
3	Multiply line 2a by line 2b and enter the amount here and on Part I, line 14	3
4	Explain below why you qualify for a 20% rather than a 50% excise tax rate:	

[redacted]

Schedule J. Tax on Failure To Provide Notice of Significant Reduction in Future Accruals (Section 4980F) Reported by the last day of the month following the month in which the failure occurred

1	Enter the number of applicable individuals who were not provided ERISA section 204(h) notice:	
2	Enter the effective date of the amendment MM DD YY	
3	Enter the number of days in the noncompliance period:	
4	Enter the total number of failures to provide ERISA section 204(h) notice. See instructions	[redacted]
5	Multiply line 4 by $100. Enter here and on Part I, line 15	
6	Provide a brief description of the failure, and of the correction, if any:	

[redacted]

Schedule K. Tax on Prohibited Tax Shelter Transactions (Section 4965) Reported on or before the 15th day of the 5th month following the close of the entity manager's tax year during which the plan became a party to a prohibited tax shelter transaction

1	Enter the number of prohibited tax shelter transactions you caused the same plan to be a party to: _____	
2	Multiply line 1 by $20,000. Enter the result here and on Part I, line 16	2

Schedule L. Tax on Failure of a CSEC Plan Sponsor To Adopt Funding Restoration Plan (Section 4971(h)) Reported by the 15th day of the 10th month after the last day of the plan year

1	Enter the number of days during the tax year which are included in the period beginning on the day following the close of the 180-day period described in section 433(j)(3) and ending on the day on which the funding restoration plan is adopted	2
2	Multiply line 1 by $100. Enter the result here and on Part I, line 10d	

Attachment to 2025 Form 5500

Schedule H, line 4i - Schedule of Assets
(Held at End of Year)
OBHG 401(K) PLAN
EIN#80-0950275
Plan# 002
As of December 31, 2025

(a)	(b) Identity of issue, borrower,lessor or similar party	(c) Description of investments including maturity date,rate of interest, collateral, par, or maturity date	(d)Cost	(e) Current Value
	AmCen Ultra Fund R6	Registered Investment Company		$7,805,946
	Amer Fnds Mod Grw & Inc R6	Registered Investment Company		$3,033,314
	Amer Fnds New Perspective R6	Registered Investment Company		$2,028,599
	DFA Emerging Markets Pt Ins	Registered Investment Company		$1,837,524
	DFA Infl-Prot Sec Port Ins	Registered Investment Company		$2,019,497
	DFA Intl Core Eq 2-Inst	Registered Investment Company		$1,912,972
	DFA Large Cap Intl Port Ins	Registered Investment Company		$1,188,530
	Dodge & Cox Income Fd I	Registered Investment Company		$3,517,372
	Fidelity Intl Index Fnd	Registered Investment Company		$2,947,237
	Fidelity Mid Cap Growth Idx Fd	Registered Investment Company		$1,231,175
	Fidelity Real Est Invest Port	Registered Investment Company		$1,462,299
	GG Tr TRP Ret Date 2005 Tr	Common Collective Trust		$89,680
	GG Tr TRP Ret Date 2010 Tr	Common Collective Trust		$757,112
	GG Tr TRP Ret Date 2015 Tr	Common Collective Trust		$2,011,463
	GG Tr TRP Ret Date 2020 Tr	Common Collective Trust		$2,029,420
	GG Tr TRP Ret Date 2025 Tr	Common Collective Trust		$4,089,404
	GG Tr TRP Ret Date 2030 Tr	Common Collective Trust		$9,557,837
	GG Tr TRP Ret Date 2035 Tr	Common Collective Trust		$9,396,180
	GG Tr TRP Ret Date 2040 Tr	Common Collective Trust		$8,114,399
	GG Tr TRP Ret Date 2045 Tr	Common Collective Trust		$7,011,868
	GG Tr TRP Ret Date 2050 Tr	Common Collective Trust		$5,757,455
	GG Tr TRP Ret Date 2055 Tr	Common Collective Trust		$1,492,953

Attachment to 2025 Form 5500

Schedule H, line 4i - Schedule of Assets
(Held at End of Year)
OBHG 401(K) PLAN
EIN#80-0950275
Plan# 002

	GG Tr TRP Ret Date 2060 Tr	Common Collective Trust		$509,736
	GG Tr TRP Ret Date 2065 Tr	Common Collective Trust		$806,218
	Inv Discovery Fd Y	Registered Investment Company		$535,907
	Invesco Small Cap Value Fd R6	Registered Investment Company		$904,406
	John Hanck Dis Val Md Cp Fd I	Registered Investment Company		$666,389
	MFS Glbl Opp Bnd Fund R6	Registered Investment Company		$475,995
	MFS Research Intl Fund R6	Registered Investment Company		$1,319,577
	MnNpr Rainier Intl Disc Srs Z	Registered Investment Company		$540,652
	PGIM High Yield Fund R6	Registered Investment Company		$578,219
	PIMCO Income Fund Ins	Registered Investment Company		$838,564
	Putnam Intl Value Fund R6	Registered Investment Company		$265,957
	Vangrd 500 Index Fund Adm	Registered Investment Company		$21,604,838
	Vangrd Equity Income Fund Adm	Registered Investment Company		$4,036,513
	Vangrd Int-Trm Tr In Fd Adm	Registered Investment Company		$2,156,909
	Vangrd LifeStrat Cns Gr Fd Inv	Registered Investment Company		$555,613
	Vangrd LifeStrat Grw Fd Inv	Registered Investment Company		$5,023,973
	Vangrd LifeStrat Inc Fd Inv	Registered Investment Company		$297,851
	Vangrd LifeStrat Md Grw Fd Inv	Registered Investment Company		$1,375,587
	Vangrd Mid-Cap Index Fund Adm	Registered Investment Company		$3,803,140
	Vangrd Mid-Cap Vl Indx Fnd Adm	Registered Investment Company		$1,494,733
	Vangrd Small-Cap Index Fnd Adm	Registered Investment Company		$4,596,398
*	Voya Fixed Account (4450)	Insurance Company General Account		$4,892,403
*	Voya Gv Mny Mkt F A (Hld Acct)	Registered Investment Company		$57,184
	LOAN FUND	Participant Loans - Rates 5.25% to 10.50%		$544,218
	TOTAL			$137,173,214

*** denotes party-in-interest**

Attachment to 2025 Form 5500

Schedule H, line 4i - Schedule of Assets
(Held at End of Year)
OBHG 401(K) PLAN
EIN#80-0950275
Plan# 002

Column (d) is not required as the Plan investments are totally participant directed.