

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 2021 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
	☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report
	☒ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558 ☒ automatic extension ☐ the DFVC program
	☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan <u>EMPLOYEE BENEFITS PLAN OF CARESOUTH</u>
1b	Three-digit plan number (PN) ▶ <u>001</u>
1c	Effective date of plan <u>01/01/2016</u>
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) <u>CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED</u> <u>CARESOUTH</u> <u>3111 FLORIDA ST</u> <u>BATON ROUGE, LA 70806-3773</u>
2b	Employer Identification Number (EIN) <u>72-1395500</u>
2c	Plan Sponsor's telephone number <u>225-650-2000</u>
2d	Business code (see instructions) <u>621112</u>

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.	10/18/2022	MAIMOUNA KEITA
	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

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

Form 5500 (2021)
v. 210624

3a Plan administrator's name and address ☒ Same as Plan Sponsor		3b Administrator's EIN
		3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name		4b EIN 4d PN
5 Total number of participants at the beginning of the plan year		5 166
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) 158
a(2) Total number of active participants at the end of the plan year		6a(2) 147
b Retired or separated participants receiving benefits.....		6b 0
c Other retired or separated participants entitled to future benefits		6c 25
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d 172
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e 0
f Total. Add lines 6d and 6e		6f 172
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g 160
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		6h 24
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 Characteristics Codes in the instructions: 2F 2G 2S 2T 3D		
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:		
9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)		
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>3</u> A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☒ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)	

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☒ No

11c Enter the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 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 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021	
A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED	D Employer Identification Number (EIN) 72-1395500

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier GUARDIAN					
(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
13-5123390	64246	00569162	133	01/01/2021	12/31/2021

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 42915	(b) Total amount of fees paid 6679
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
000VS615-WAMPOLD INSURANCE CO LLC	4517 PINE RIDGE DRIVE BATON ROUGE, LA 70809

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
19276	0		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
000BI801-AGM BENEFIT SOLUTIONS	8550 UNITED PLAZA BLVD SUITE 210 BATON ROUGE, LA 70809

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
23639	6679	GROUP INSURANCE COVERAGE FEES	

(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
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(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	
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. Specify nature of costs ▶	6d	

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 ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ 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	244057
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. Specify nature of costs.	10b	

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 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 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021	
A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED	D Employer Identification Number (EIN) 72-1395500

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier
MUTUAL OF AMERICA

(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
13-1614399	88668	058030B	172	01/01/2021	12/31/2021

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
0	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

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

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	(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	165327
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	2076547

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶ **N/A**

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. Specify nature of costs ▶ N/A	6d	

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 ▶

b	Balance at the end of the previous year	7b	95999
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c	Additions: (1) Contributions deposited during the year	7c(1)	75219	
	(2) Dividends and credits.....	7c(2)	0	
	(3) Interest credited during the year.....	7c(3)	1324	
	(4) Transferred from separate account.....	7c(4)	0	
	(5) Other (specify below)	7c(5)	56	

▶ **ROLLOVER; LOAN INT PAY**

(6) Total additions	7c(6)	76599
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d	Total of balance and additions (add lines 7b and 7c(6))	7d	172598
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	2806	
(2) Administration charge made by carrier.....	7e(2)	112	
(3) Transferred to separate account.....	7e(3)	0	
(4) Other (specify below)	7e(4)	4353	

▶ **FIN ADJ.**

(5) Total deductions	7e(5)	7271
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f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	165327
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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	0
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. Specify nature of costs.	10b	0

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 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 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021	
A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED	D Employer Identification Number (EIN) 72-1395500

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier
BLUE CROSS AND BLUESHIELD OF LA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-7384555	81200	83890FF2	202	01/01/2021	12/31/2021

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 36227	(b) Total amount of fees paid 32961
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
02778-WAMPOLD INSURANCE CO LLC
8768 QUARTERS LAKE RD
BATON ROUGE, LA 70809

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
36227	32961	INDIRECT COMPENSATION	

(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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ 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	1102829
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. Specify nature of costs.	10b	

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) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2021
		This Form is Open to Public Inspection.
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021		
A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED	D Employer Identification Number (EIN) 72-1395500	

Part I	Service Provider Information (see instructions)
---------------	--

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☒ Yes ☐ No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
DELAWARE FUNDS	ONE COMMERCE SQUARE 2005 MARKET STREET PHILADELPHIA, PA 19103
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
GOLDMAN SACHC VIT FUNDS	200 WEST STREET NEW YORK, NY 10282
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
NEUBERGER BERMAN	1290 AVENUE OF THE AMERICAS NEW YORK, NY 10104
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
VICTORY FUNDS	4900 TIEDEMAN ROAD 4TH FLOOR BROOKLYN, OH 44144

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

MFS

111 HUNTINGTON AVENUE
BOSTON, MA 02199

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

T. ROWE PRICE

100 EAST PRATT STREET
BALTIMORE, MD 21202

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

PIMCO

840 NEWPORT CENTER DRIVE
NEWPORT BEACH, CA 92660

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

AMERICAN FUNDS

333 SOUTH HOPE STREET
LOS ANGELES, CA 90071

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

CALVERT

4550 MONTGOMERY AVENUE SUITE 1000N
BETHESDA, MD 20814

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

AMERICAN CENTURY INVESTMENTS

P O BOX 419786
KANSAS CITY, MO 64141

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

INVESCO VI MAIN STREET

P O BOX 5270
DENVER, CO 80127

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

DWS

222 SOUTH RIVERSIDE PLAZA
CHICAGO, IL 60606

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

VANGUARD

P O BOX 2600
VALLEY FORGE, PA 19482

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

FIDELITY INVESTMENTS

82 DEVONSHIRE STREET
BOSTON, MA 02109

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

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

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

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

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

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

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)

MUTUAL OF AMERICA INVESTMENT CORP

320 PARK AVENUE
NEW YORK, NY 10022

(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?
12 15 37 65	INSURANCE CARRIER	541	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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)

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE 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 2021 This Form is Open to Public Inspection.	
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021					
A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH				B Three-digit plan number (PN) ▶ 001	
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED				D Employer Identification Number (EIN) 72-1395500	
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: SEPARATE ACCOUNT NUMBER FS1					
b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA					
c EIN-PN 13-1614399-000		d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2076547		
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)		
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)		

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

Schedule D (Form 5500) 2021 v. 201209

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)**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)**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)

(Complete as many entries as needed to report all participating plans)

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 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>		
A Name of plan <u>EMPLOYEE BENEFITS PLAN OF CARESOUTH</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED</u>	D Employer Identification Number (EIN) <u>72-1395500</u>	

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)	26287	32303
(9) Value of interest in common/collective trusts.....	1c(9)		
(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)	1295480	2076547
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	95999	165327
(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)	
e	Buildings and other property used in plan operation	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	1417766 2274177
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	
i	Acquisition indebtedness.....	1i	
j	Other liabilities.....	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	0 0
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	1417766 2274177

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.

		(a) Amount	(b) Total
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	209437
	(B) Participants	2a(1)(B)	404385
	(C) Others (including rollovers).....	2a(1)(C)	47462
(2)	Noncash contributions.....	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	661284
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)	1521
	(F) Other	2b(1)(F)	1323
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	2844
(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)	
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	0
(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)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		235749
(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)		
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		899877
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	39719	
(2) To insurance carriers for the provision of benefits.....	2e(2)	0	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		39719
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees.....	2i(1)		
(2) Contract administrator fees.....	2i(2)		
(3) Investment advisory and management fees.....	2i(3)		
(4) Other.....	2i(4)	3747	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		3747
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		43466
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d.....	2k		856411
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) ☐ Unmodified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: BROWN, EWING & CO., P.A.

(2) EIN: 64-0669040

d The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, 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.

During the plan year:

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.).....

	Yes	No	Amount
4a		X	

	Yes	No	Amount
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	
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			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ 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 2021 This Form is Open to Public Inspection.
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan EMPLOYEE BENEFITS PLAN OF CARESOUTH	B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 CAPITOL CITY FAMILY HEALTH CENTER INCORPORATED	D Employer Identification Number (EIN) 72-1395500

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	0
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): 13-3590259		
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

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

Schedule R (Form 5500) 2021
v. 201209

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (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) through (c)

a Enter the percentage of plan assets held as:

Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:

☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?

☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

- 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 _____

**CAPITOL CITY FAMILY HEALTH
CENTER 401K PROFIT SHARING PLAN & TRUST**

AUDITED FINANCIAL STATEMENTS

December 31, 2021 and 2020

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
December 31, 2021

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BROWN, EWING & CO.
P. A.
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Capitol City Family Health Center
401K Plan & Trust
Baton Rouge, Louisiana

Scope and Nature of the ERISA Section 103(a)(3)(C) Audit

We have performed the audit of the accompanying financial statements of Capitol City Family Health Center 401K Profit Sharing Plan & Trust, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) [ERISA Section 103(a)(3)(C) audit]. The financial statements comprise the statements of net assets available for benefits as of the year ended December 31, 2021, and the related statement of changes in net assets available for benefits for the year ended December 31, 2021 and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of Capitol City Family Health Center 401K Profit Sharing Plan & Trust's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from a qualified institution as of December 31, 2021, stating that the certified investment information, as described in Note 4 to the financial statements, is complete and accurate.

Opinion

In our opinion, based on our audits and on the procedures performed as described in the Auditor's Responsibilities for the Audit of the Financial Statements section—

- the amounts and disclosures in the financial statements referred to above, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- the information in the financial statements referred to above related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Capitol City Family Health Center 401K Profit Sharing Plan & Trust and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Capitol City Family Health Center 401K Profit Sharing Plan & Trust's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments; administering the plan; and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Capitol City Family Health Center 401K Profit Sharing Plan & Trust's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Capitol City Family Health Center 401K Profit Sharing Plan & Trust's ability to continue as a going concern for a reasonable period of time.

Our audits did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

The supplemental schedules of are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, other than the information agreed to or derived from the certified investment information, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion—

- the form and content of the supplemental schedules, other than the information in the supplemental schedules that agreed to or is derived from the certified investment information, are presented, in all material respects, in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.
- the information in the supplemental schedules related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

Brown, Eyring & Co.
Ridgeland, Mississippi
October 14, 2022

EXHIBIT I

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Statement of Net Assets Available for Benefits
December 31, 2021 and 2020

Assets	<u>2021</u>	<u>2020</u>
Investment contract with insurance company	\$ 165,327	\$ 95,999
Registered investment companies	<u>2,076,547</u>	<u>1,295,480</u>
Total Investments at Fair Value	<u>2,241,874</u>	<u>1,391,479</u>
Receivables:		
Notes receivable from participants	<u>32,303</u>	<u>26,287</u>
	<u>32,303</u>	<u>26,287</u>
Total Assets	<u>2,274,177</u>	<u>1,417,766</u>
Liabilities:	<u>-</u>	<u>-</u>
Total Liabilities	<u>-</u>	<u>-</u>
Net Assets Available For Benefits	<u>\$ 2,274,177</u>	<u>\$ 1,417,766</u>

The accompanying notes are an integral part of these financial statements.

EXHIBIT II

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Statement of Changes in Net Assets Available for Benefits
For the Year Ended December 31, 2021 and 2020

	<u>2021</u>	<u>2020</u>
ADDITIONS		
Additions to net assets attributed to:		
Investment Activity:		
Net appreciation (depreciation) in fair value of investments	\$ 235,749	\$ 323,739
Interest and dividends	<u>2,844</u>	<u>1,489</u>
Net Investment Gain (Loss)	<u>238,593</u>	<u>325,228</u>
Employer Contributions	209,437	94,912
Participant Contributions	404,385	188,562
Other Contributions	<u>47,462</u>	<u>-</u>
Total Contributions	<u>661,284</u>	<u>283,474</u>
Total Additions	<u>899,877</u>	<u>608,702</u>
DEDUCTIONS		
Deductions from net assets attributed to:		
Benefits paid directly to participants	39,719	55,887
Administrative expenses	<u>3,747</u>	<u>451</u>
Total deductions	<u>43,466</u>	<u>56,338</u>
Net Increase (Decrease)	856,411	552,364
Net Assets Available for Benefits, Beginning of Year	<u>1,417,766</u>	<u>865,402</u>
Net Assets Available for Benefits, End of Year	<u>\$ 2,274,177</u>	<u>\$ 1,417,766</u>

The accompanying notes are an integral part of these financial statements.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 1 - DESCRIPTION OF THE PLAN

The following description of the Capitol City Family Health Center 401K Profit Sharing Plan & Trust (Plan) provides only general information. Participants should refer to the Plan Document which is available from the plan administrator, for a more complete description of the Plan's provisions.

General

The Plan, which was adopted effective January 1, 2016 is a defined contribution plan. All full-time employees of Capitol City Family Health Center, Inc. D/B/A Care South who have six (6) months of service are eligible for the Plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Each year, participants may contribute up to 6% of pretax annual compensation, as defined in the Plan. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing contributions from other qualified defined benefit or contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan.

The amount of matching contributions made on behalf of an eligible participant each plan year shall be an amount of up to 100% of the eligible participant's employee elective deferral which does not exceed 3% of their compensation..

Participant Accounts

Under the Plan, a separate account is maintained for each participant. Participant contributions and employer contributions are allocated to each participant's account.

The Employer will make additions to participant's accounts for (a) participant's allocated share of the Employer's contribution, (b) participant's transfer contributions and rollover contributions, and (c) participant's share of investment earnings and appreciation in the value of investments. The Employer will make deductions from participant's accounts for (d) any withdrawals or distributions made to participants, (e) participant's share of investments losses and depreciation in the value of investments, and (f) participant's share of any administrative fees and expenses paid out of the Plan, if applicable.

During the year ended December 31, 2021, Plan investments were held at Mutual of America herein referred to as the "Custodians" of the Plan.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 1 - DESCRIPTION OF THE PLAN (Continued)

Vesting

A participant is 100% vested after six years of credited service. Participants are considered to have completed one year of service for purposes of vesting upon the completion of 1,000 hours of service at any time during a Plan year. Participant's are immediately vested in their voluntary contributions, rollover contributions, or transfer contributions, plus or minus any earnings or losses and these contributions cannot be forfeited for any reason. Participants are vested as determined by the following schedule:

<u>Years of Service</u>	<u>Vested Interest</u>
1	- %
2	20 %
3	40 %
4	60 %
5	80 %
6	100 %

Payment of Benefits

On termination of service due to death, disability or retirement, a participant may elect to receive an amount equal to the value of the participant's vested interest in his or her account in a lump-sum amount. Request must be submitted in writing to the Plan Administrator. Payments to participant's will start as soon as administratively feasible following the date on which a distribution is requested by participant or is otherwise payable.

Forfeitures

Forfeitures are created when a Participant terminated employment before becoming entitled to 100% of the Accounts derived from the Employer's contributions. There was no unallocated forfeiture balance as of December 31, 2021.

Plan Termination

Although it has not expressed an intention to do so, Capitol City Family Health Center, Inc. D/B/A Care South has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA. In the event of plan termination, participant's individual accounts will become 100% vested in the aggregate value regardless of years of service under the vesting schedule. The employer may amend the Plan at any time, provided that no amendment will divert any part of the Plan's assets to any purpose other than for the exclusive benefit of the Participants in the Plan or eliminate an optional form of distribution.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the plan are prepared on the accrual basis of accounting.

Investment contracts held by a defined contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the plan. The Statement of Net Assets Available for Benefits presents the fair value of the investment contracts as well as the adjustment of the fully benefit-responsive investment contracts from fair value to contract value. The Statement of Changes in Net Assets Available for Benefits is prepared using contract value for the fully benefit-responsive investment contract.

Investment Valuation and Income Recognition

The Plan's investments are exclusively in annuity contracts issued by Mutual of America. These contracts provide for contributions to be held and credited with interest, gains and losses, depending on the type of contract. They are valued at fair market value.

Notes Receivable from Participants

Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their account balance. During the repayment period, principal and interest must be repaid in substantially level repayments and made at least quarterly. Loan repayments are made on an after-tax basis. These repayments may be made by payroll deduction, Electronic Funds Transfer(EFT) or by personal check.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America and with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Plan Tax Status

This 401K Profit Sharing Plan is not currently required to submit plans to the Internal Revenue Services for status determination. The Plan Administrator believes that the Plan was designed and is being operated in compliance with the approvals required of the Internal Revenue Code and as such is exempt from Federal Income Taxes.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Accounting principles generally accepted in the United States of America require the plan administrator to evaluate tax positions taken by the Plan and recognize a tax liability for any uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by tax authorities; however, there are currently no audits for any tax periods in progress. The Plan administrator believes the Plan is no longer subject to income tax examinations for years prior to 2021.

Payment of Benefits

Benefit payments to participants are recorded when paid.

NOTE 3 - FAIR VALUE MEASUREMENTS

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits.

		Fair Value Measurement at Reporting Date Using:		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<u>December 31, 2021</u>	<u>Fair Value</u>			
Registered investment companies	\$ 2,076,547	\$ 2,076,547	\$ -	\$ -
Investment contract with insurance company	<u>165,327</u>	<u>-</u>	<u>-</u>	<u>165,327</u>
Total	<u>\$ 2,241,874</u>	<u>\$ 2,076,547</u>	<u>\$ -</u>	<u>\$ 165,327</u>

ASC 820, *Fair Value Measurements*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level 1 inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority, Level 2 inputs consist of observable inputs other than quoted prices for identical assets, and Level 3 inputs have the lowest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. Level 3 inputs were used only when Level 1 or Level 2 inputs were not available.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 3 - FAIR VALUE MEASUREMENTS (Continued)

Level 1 Fair Value Measurements

The fair values of mutual funds are valued at the net asset value (NAV) of shares held by the plan at year end and real estate investment trusts are based on quoted market prices, when available.

		Fair Value Measurement at Reporting Date Using:		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<u>December 31, 2020</u>	<u>Fair Value</u>			
Registered investment companies	\$ 1,295,480	\$ 1,295,480	\$ -	\$ -
Investment contract with insurance company	95,999	-	-	95,999
Total	<u>\$ 1,391,479</u>	<u>\$ 1,295,480</u>	<u>\$ -</u>	<u>\$ 95,999</u>

Level 2 Fair Value Measurements

Inputs based on quoted prices in markets that are not active or model inputs that are observable, either directly or indirectly, for substantially the full term of the asset or liability, such as quoted prices for similar assets or liabilities in active markets.

Level 3 Fair Value Measurement

The guaranteed investment with an insurance company is not actively traded and significant other observable inputs are not available. Thus, the fair value of the guaranteed investment contract is determined by discounting the related cash flows based on current yields of similar instruments with comparable durations. The following table provides further details of the Level 3 fair value measurements.

Fair Value Measurements Using Significant Unobservable Inputs (Level 3)

<u>December 31, 2021</u>	<u>Investment Contract with Insurance Company</u>
Beginning balance	\$ 95,999
Purchases, sales, issuances, settlements, (net)	69,328
Total	<u>\$ 165,327</u>

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Notes to the Financial Statements
December 31, 2021 and 2020

NOTE 4 - INFORMATION PREPARED AND CERTIFIED BY THE TRUSTEE

The following information included in the accompanying financial statements and supplemental schedules was obtained from data that has been prepared and certified to as complete and accurate by Mutual of America:

	<u>2021</u>	<u>2020</u>
Mutual Funds	\$ 2,076,547	\$ 1,295,480
Investments at Contract Value	<u>165,327</u>	<u>95,999</u>
	<u>\$ 2,241,874</u>	<u>\$ 1,391,479</u>

NOTE 5 - RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investments securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net asset available for benefits.

NOTE 6 - RELATED PARTY TRANSACTIONS

Certain Plan investments are managed by Mutual of America. Mutual of America is the custodian as defined by the Plan and, therefore, these investments and investment transactions qualify as party-in-interest transactions.

NOTE 7 - SUBSEQUENT EVENTS

Subsequent events have been evaluated through October 14, 2022, which represents the date the financial statements were available to be issued. Subsequent events after that date have not been evaluated.

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST

SUPPLEMENTARY INFORMATION

December 31, 2021

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Schedule H, Line 4I - Schedule of Assets (Held at End of Year)
For the Year Ended December 31, 2021

(a)	(b) Identity of Issue, borrower, lessor or similar party	(c) Description of Investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current Value
		Shares in registered investment companies:		
*	Mutual of America	General Account	-	\$ 165,327
*	Mutual of America	Agressive Allocation Fund	-	898
*	Mutual of America	Moderate Allocation Fund	-	36
*	Mutual of America	Bond Fund	-	885
*	Mutual of America	T. Rowe Price Blue Chip Growth	-	95,887
*	Mutual of America	Composite Fund	-	12
*	Mutual of America	Calvert UP SRI Balanced Port.	-	1,589
*	Mutual of America	Delaware VIP Small Cap Value S	-	205
*	Mutual of America	Equity Index Fund	-	9,844
*	Mutual of America	Fidelity VIP Mid-Cap	-	26,346
*	Mutual of America	Fidelity VIP Asset Manager	-	5,639
*	Mutual of America	Fidelity VIP Contrafund	-	6,159
*	Mutual of America	Fidelity VIP Equity Income	-	27,465
*	Mutual of America	Goldman Sachs VIT US Equity	-	23,547
*	Mutual of America	Goldman Sachs VIT Small Cap	-	6,238
*	Mutual of America	American Funds IS New World	-	1,515
*	Mutual of America	Money Market Fund	-	10,557
*	Mutual of America	Mid-Term Bond Fund	-	51,732
*	Mutual of America	Mid-Cap Equity Index Fund	-	111
*	Mutual of America	MFS VIT III Mid Cap Value Port	-	3,463
*	Mutual of America	Mid Cap Value Fund	-	116
*	Mutual of America	Neuberger Berman AMT Sust Eq	-	3,954
*	Mutual of America	International Fund	-	2,699
*	Mutual of America	Invesco Oppenheimer VI Main St	-	2,423
*	Mutual of America	Retirement Income Fund	-	64,189
*	Mutual of America	Vanguard VIF Real Estate Index	-	16,974
*	Mutual of America	PIMCO VIT Real Return	-	2,100
*	Mutual of America	Victory RS Small Cap Growth	-	2,797
*	Mutual of America	2020 Retirement Fund	-	145,654
*	Mutual of America	2025 Retirement Fund	-	73,110
*	Mutual of America	2030 Retirement Fund	-	250,470
*	Mutual of America	2035 Retirement Fund	-	175,211
*	Mutual of America	2040 Retirement Fund	-	440,259
*	Mutual of America	2045 Retirement Fund	-	265,766
*	Mutual of America	2050 Retirement Fund	-	63,097
		Sub-total	-	<u>1,946,274</u>

CAPITOL CITY FAMILY HEALTH CENTER 401K PROFIT SHARING PLAN & TRUST
Schedule H, Line 4I - Schedule of Assets (Held at End of Year)
For the Year Ended December 31, 2021

(a)	(b) Identity of Issue, borrower, lessor or similar party	(c) Description of Investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current Value
		Shares in registered investment companies:		
*	Mutual of America	2055 Retirement Fund	-	\$ 108,976
*	Mutual of America	2060 Retirement Fund	-	40,624
*	Mutual of America	2065 Retirement Fund	-	1,968
*	Mutual of America	All America Fund	-	50
*	Mutual of America	Small Cap Equity Index Fund	-	35
*	Mutual of America	DWS Capital Growth VIP	-	2,334
*	Mutual of America	Small Cap Growth Fund	-	14,171
*	Mutual of America	Small Cap Value Fund	-	36
*	Mutual of America	American Century VP Cap Apprec	-	22,849
*	Mutual of America	Vanguard VIF Diversified Value	-	43,014
*	Mutual of America	Vanguard VIF International	-	13,080
*	Mutual of America	Vanguard Total Bond Mkt I Pft	-	48,463
*	Participant Loans	Participant Loans	-	32,303
		Sub-total	-	<u>327,903</u>
		Total Assets (Held at Year End)	-	\$ <u>2,274,177</u>

* A party-in-interest as defined by ERISA

Note: Cost information has not been included in column (d) because all investments are participant directed transactions under an individual account plan.

Mutual of America -- Participant Level Transaction Report

Employer Number: 058030 -- 401K Thrift Plan -- Period: December 31 , 2020 To December 31 , 2021

CONFIDENTIAL

This report contains confidential retirement plan participant account information which may be protected by applicable privacy regulations. The information is intended only for the entity named above and its authorized representatives. Any unauthorized copying, distribution or disclosure is prohibited.

ID	First Name	Init	Last Name	Opening Balance	Adjustments	Additions	Deductions	Transfers	Investment Earnings	Closing Balance
xxx-xx-0100	Patricia		Harris	1,599.02	0.00	2,501.48	-4,599.25		498.75	0.00
xxx-xx-0212	Constance	H	McNeely	726.49	0.00	4,441.72	-21.34		30.00	5,176.87
xxx-xx-0299	Yesenia		Hernandez	514.94	0.00	2,296.28	0.00		263.79	3,075.01
xxx-xx-0375	Cortlynn	M	Cavalier	0.00	0.00	1,070.12	-5.76		77.25	1,141.61
xxx-xx-0442	Kenya	L	Nelson	47,963.61	0.00	10,280.71	0.00		9,800.61	68,044.93
xxx-xx-0447	Austin		Matthews	7,661.71	0.00	0.00	-24.00		1,543.81	9,181.52
xxx-xx-0468	Andrekia	S	Smith	531.94	0.00	2,175.79	0.00		16.52	2,724.25
xxx-xx-0774	Charles	L	James	0.00	0.00	387.46	-0.63		13.34	400.17
xxx-xx-0842	Tikeleanna		Dutton	5,366.30	0.00	0.00	-5,521.16		154.86	0.00
xxx-xx-0880	Tameka		Reddix	8,555.42	0.00	2,983.40	-24.00		1,898.27	13,413.09
xxx-xx-0900	Nicole	L	Berthelot	16,274.37	0.00	5,300.22	0.00		3,589.79	25,164.38
xxx-xx-1060	Tanisha		Williams	1,264.82	0.00	2,600.01	0.00		26.24	3,891.07
xxx-xx-1073	Shermaine		Venable	1,481.82	0.00	2,361.19	0.00		470.74	4,313.75
xxx-xx-1112	Kennedi	C	Banks	0.00	0.00	56.14	0.00		2.26	58.40
xxx-xx-1142	Christy	L	Thomas	249.18	0.00	516.54	-386.17		4.24	383.79
xxx-xx-1166	Traci		Woodard	4,891.49	0.00	0.00	-6.00		926.66	5,812.15
xxx-xx-1229	Valerie	M	Sims	240.56	0.00	572.00	-5.35		5.34	812.55
xxx-xx-1258	Helanna		Brown	1,428.86	0.00	2,887.18	0.00		470.00	4,786.04
xxx-xx-1278	Latoya	M	Decuir	293.86	0.00	1,340.64	-10.81		152.92	1,776.61
xxx-xx-1279	Latoya	J	Edwards	1,528.69	-1,300.00	3,345.11	0.00		27.35	3,601.15
xxx-xx-1320	Katie	L	Medine	10,623.74	0.00	0.00	-24.00		2,111.45	12,711.19
xxx-xx-1402	Walter	L	Campbell Jr	16,488.18	0.00	4,089.58	-14.00		899.66	21,463.42
xxx-xx-1403	Hieu		Vuong	77,526.52	0.00	19,464.25	0.00		12,236.88	109,227.65
xxx-xx-1420	Dionne		Bell	45,475.44	0.00	9,758.28	0.00		9,637.91	64,871.63
xxx-xx-1504	Matthew		Valliere	87,229.97	0.00	26,237.40	0.00		18,419.39	131,886.76
xxx-xx-1573	shantelle	E	Price-Hagans	2,229.46	-1,500.00	1,077.72	0.00		224.37	2,031.55
xxx-xx-1605	Nancy		Meagher	212.79	0.00	0.00	-213.35		0.56	0.00
xxx-xx-1625	Y'Mine		McClanahan	2,193.48	0.00	8,662.06	-14.00		1,106.84	11,948.38
xxx-xx-1649	Marcia	S	Booker	0.00	0.00	306.92	-313.03		6.11	0.00
xxx-xx-1705	Chelsea	M	Jagot	0.00	0.00	425.22	-0.99		16.42	440.65
xxx-xx-1763	Richshell		Webb	1,057.86	0.00	1,117.67	-2,348.81		173.28	0.00
xxx-xx-1826	Dillon	M	Demby	189.40	0.00	0.00	-200.91		11.51	0.00

xxx-xx-1848	Sharon		Litt	9,520.45	0.00	2,767.99	0.00	1,177.71	13,466.15
xxx-xx-1851	Tonya	D	Scott	3,418.75	0.00	2,800.60	0.00	776.65	6,996.00
xxx-xx-1918	Da'Nethia		Saunders	137.44	0.00	5,151.70	0.00	376.26	5,665.40
xxx-xx-1958	Debra		Cooper	1,919.79	0.00	5,409.16	0.00	750.75	8,079.70
xxx-xx-1988	Betty		Vandiver	2,000.45	0.00	3,745.17	0.00	38.82	5,784.44
xxx-xx-2008	Selina	G	Patin	3,232.63	-2,514.00	3,903.72	0.00	39.80	4,662.15
xxx-xx-2026	Kathy	G	Ennis	0.00	0.00	158.34	-159.85	1.51	0.00
xxx-xx-2091	Cletis	L	Tucker	1,121.56	0.00	774.08	-10.36	235.19	2,120.47
xxx-xx-2107	Patricia		Richard	2,082.63	0.00	2,666.55	-23.89	346.29	5,071.58
xxx-xx-2407	Elizabeth		Bujnoch	0.00	0.00	588.48	0.00	4.06	592.54
xxx-xx-2432	Kevin		Paul	1,810.16	0.00	4,023.84	-23.77	267.57	6,077.80
xxx-xx-2461	Narkita	W	Roscoe	29,498.95	0.00	8,126.08	0.00	4,873.08	42,498.11
xxx-xx-2502	Syretta	D	Anthony	1,827.15	0.00	3,001.48	0.00	554.61	5,383.24
xxx-xx-2518	Mijetta		Pruitt	0.00	0.00	50.52	-52.82	2.30	0.00
xxx-xx-2620	Tyesha	A	Smith	5,700.33	0.00	0.00	-24.00	1,132.12	6,808.45
xxx-xx-2731	Asia		Drewery	1,158.52	-1,810.00	3,288.14	-2.59	481.56	3,115.63
xxx-xx-2784	Dania	M	Gomez-Lopez	224.80	0.00	1,007.06	-8.47	122.16	1,345.55
xxx-xx-2792	Jane		Ampim	31,007.01	0.00	17,982.65	0.00	6,373.84	55,363.50
xxx-xx-2811	Valerie		Favorite	5,725.31	0.00	2,428.59	0.00	69.65	8,223.55
xxx-xx-2845	Terry		Johnson	778.58	0.00	1,474.98	-16.47	149.67	2,386.76
xxx-xx-2846	Steven	S	Smith	1,015.99	0.00	148.38	-10.77	299.21	1,452.81
xxx-xx-2887	Charles	H	Martin	3,450.46	0.00	0.00	-24.00	495.40	3,921.86
xxx-xx-2888	Sheneka	L	Dunn	507.02	0.00	1,644.02	0.00	216.23	2,367.27
xxx-xx-2898	Rayett	S	Lockette	6,525.62	0.00	3,218.40	0.00	1,245.81	10,989.83
xxx-xx-3010	Afton	K	Dunn	6,482.86	0.00	1,507.16	-24.00	1,393.30	9,359.32
xxx-xx-3107	Kathy		Breaux	21,141.58	-3,500.00	5,531.79	0.00	4,285.40	27,458.77
xxx-xx-3127	Tracy	L	Jefferson	10,222.48	0.00	4,662.11	0.00	2,255.00	17,139.59
xxx-xx-3142	Shandreka		Greene	0.00	0.00	439.50	-473.93	34.43	0.00
xxx-xx-3146	John	F	Day Jr	11,221.07	0.00	2,412.92	0.00	91.31	13,725.30
xxx-xx-3181	Anthony		Gonzalez	1,954.07	0.00	54,869.98	-24.00	6,149.41	62,949.46
xxx-xx-3254	Ebony		Daigre	841.13	0.00	3,402.02	-21.23	409.24	4,631.16
xxx-xx-3314	Tara		Snearl	0.00	0.00	623.38	-656.28	32.90	0.00
xxx-xx-3317	Eureka	M	Davidson	0.00	0.00	99.74	-103.01	3.27	0.00
xxx-xx-3325	Tomeika		Turner	0.00	0.00	322.80	-162.25	8.32	168.87
xxx-xx-3333	Dekara		Levy	1,815.48	0.00	0.00	-1,068.25	349.63	1,096.86
xxx-xx-3375	Sumanth		Punukollu	1,160.68	0.00	0.00	0.00	256.58	1,417.26
xxx-xx-3482	Angelica		Mahon	1,054.12	0.00	1,303.58	-18.60	302.55	2,641.65
xxx-xx-3558	Boiesha	A	Peck	42.64	0.00	1,596.42	-7.27	94.42	1,726.21
xxx-xx-3622	Carmen		Jones	421.51	0.00	474.76	-927.17	30.90	0.00

xxx-xx-3702	Eureka	R	Matthews Johnson	806.79	0.00	2,144.66	-18.87	303.08	3,235.66
xxx-xx-3743	Zelda	M	Pittman	740.62	0.00	5,272.00	0.00	397.86	6,410.48
xxx-xx-3769	Lauren	T	Thurmon	32,514.50	0.00	8,836.59	0.00	7,021.97	48,373.06
xxx-xx-3812	Lekeishia	r	Kinchen	0.00	0.00	1,167.54	0.00	3.50	1,171.04
xxx-xx-3831	Jennifer	M	Howard	418.98	0.00	2,821.36	0.00	18.68	3,259.02
xxx-xx-3849	Nietra	T	Chambers	247.34	0.00	1,262.88	-10.12	142.70	1,642.80
xxx-xx-3868	Eddricka		Franklin	1,572.64	0.00	6,434.07	0.00	779.42	8,786.13
xxx-xx-3955	Parissa		Khosravi	23,656.42	0.00	1,210.51	-24.00	246.16	25,089.09
xxx-xx-4174	Samantha	R	Givens-Banguel	9,341.77	0.00	6,955.13	0.00	2,385.57	18,682.47
xxx-xx-4294	Markelle	D	Williams	533.28	0.00	2,215.14	-1,300.00	235.18	1,683.60
xxx-xx-4340	Lewis		Powell	148.10	0.00	1,054.50	0.00	6.96	1,209.56
xxx-xx-4396	Rommel		Umanzor	718.62	0.00	2,967.10	0.00	359.13	4,044.85
xxx-xx-4446	Lynnell	P	Blanton	6,411.53	0.00	2,650.52	0.00	460.19	9,522.24
xxx-xx-4461	Lynn		Schechter	516.30	0.00	0.00	-5.65	87.06	597.71
xxx-xx-4475	Nichola		Williams	6,867.43	0.00	0.00	-7,034.99	438.18	270.62
xxx-xx-4493	Jacqueline		Langie	2,173.30	0.00	0.00	-22.14	105.20	2,256.36
xxx-xx-4497	Sandra		Battiste	28,008.50	0.00	11,101.31	0.00	3,595.46	42,705.27
xxx-xx-4529	Nikia		Martin	0.05	0.00	0.00	0.00	0.00	0.05
xxx-xx-4573	Darius		Hughes	3,277.25	0.00	5,037.09	0.00	974.90	9,289.24
xxx-xx-4589	Hermosa		Jones	1,652.08	0.00	3,588.69	0.00	455.74	5,696.51
xxx-xx-4604	Pamela	H	Johnson	13,863.64	-5,700.00	8,099.05	0.00	2,341.65	18,604.34
xxx-xx-4623	Lois Bridgewater	B	Doyle	44,237.81	0.00	7,422.70	0.00	-1,314.60	50,345.91
xxx-xx-4719	Alexis		Collins	1,169.60	0.00	3,081.10	-22.44	456.86	4,685.12
xxx-xx-4769	Desiree	M	Bergeron	121.79	0.00	0.00	-124.67	2.88	0.00
xxx-xx-4789	Maimouna	D	Keita	65,664.06	0.00	25,165.94	0.00	15,109.58	105,939.58
xxx-xx-4871	Rani		Whitfield	1,676.64	0.00	0.00	-18.37	282.72	1,940.99
xxx-xx-4903	Oscar	J	Reyes	0.00	0.00	198.44	0.00	26.12	224.56
xxx-xx-4908	Efraim	K	Jupiter	2,212.83	0.00	4,436.69	0.00	654.11	7,303.63
xxx-xx-5017	Yolanda	R	Cockerham	3,525.07	0.00	7,506.67	0.00	481.96	11,513.70
xxx-xx-5074	Eloisa		Lopez	0.00	0.00	903.80	-3.89	48.04	947.95
xxx-xx-5081	Brendia		Ercolini	16,665.06	0.00	6,287.34	0.00	4,361.16	27,313.56
xxx-xx-5088	Lynn		Simon	12,067.09	0.00	8,093.30	0.00	1,732.83	21,893.22
xxx-xx-5096	Nikeidra	N	Adams	0.00	0.00	355.96	-0.85	16.92	372.03
xxx-xx-5193	Janecia	R	Fountain	1,124.98	-1,352.00	2,491.23	0.00	124.75	2,388.96
xxx-xx-5200	Kimberly	W	Levy	1,786.24	0.00	3,894.79	0.00	608.73	6,289.76
xxx-xx-5229	Ingrid	N	Mackie	6,081.66	0.00	1,446.04	0.00	1,266.29	8,793.99
xxx-xx-5484	Larissa		Christophe	4,111.64	0.00	2,673.43	0.00	1,041.94	7,827.01
xxx-xx-5511	Stephanie	M	Robinson	1,541.73	0.00	0.00	0.00	306.67	1,848.40
xxx-xx-5547	Jennifer		Lacarriere	166.26	0.00	1,891.56	0.00	9.76	2,067.58

xxx-xx-5550	Kisha	S	Porter	794.82	0.00	3,937.60	0.00	28.24	4,760.66
xxx-xx-5583	Michelle	J	Hobgood	18,266.44	0.00	11,423.43	-24.00	3,353.55	33,019.42
xxx-xx-5619	Caitlyn	U	Ursin	172.18	0.00	1,028.70	0.00	116.28	1,317.16
xxx-xx-5644	Natasha	N	Pearley	290.06	0.00	0.00	0.00	56.98	347.04
xxx-xx-5646	Renarda		Ford	1,096.84	0.00	861.24	-19.88	317.43	2,255.63
xxx-xx-5819	Brittany	S	Smith	23,558.11	0.00	11,019.44	-24.00	5,024.19	39,577.74
xxx-xx-5903	D'Orsay		Bryant	0.00	0.00	4,204.42	-18.05	101.23	4,287.60
xxx-xx-5903	D'Orsay		Bryant	31,297.71	0.00	247.24	-24.00	1,533.64	33,054.59
xxx-xx-5987	Kenya		Manchester	522.71	0.00	1,549.66	-15.07	219.00	2,276.30
xxx-xx-6022	Michael		Hymbaugh	2,721.27	0.00	6,982.24	-24.00	908.03	10,587.54
xxx-xx-6095	Terriyon	L	Fairley	12,767.78	0.00	4,011.12	0.00	2,862.18	19,641.08
xxx-xx-6226	Nyasha	K	Fleming	462.62	0.00	1,125.40	-11.62	173.50	1,749.90
xxx-xx-6336	Shanna	R	Warner	5,748.39	0.00	10,813.17	0.00	1,851.91	18,413.47
xxx-xx-6495	LaRonda		James	3,195.54	0.00	4,665.97	-24.00	214.36	8,051.87
xxx-xx-6675	Emily		Taylor	8,225.03	0.00	3,437.16	0.00	4.60	11,666.79
xxx-xx-6697	Keiuna		Cropper-Patin	6,991.15	0.00	3,981.52	0.00	1,660.41	12,633.08
xxx-xx-6798	Kirstin		Franklin	2,270.29	-2,161.00	3,763.42	-10.00	560.86	4,423.57
xxx-xx-6808	Tracey		Franklin	1,562.95	0.00	2,875.70	0.00	444.91	4,883.56
xxx-xx-6867	Meyon		Hamilton	248.92	0.00	1,187.92	-862.79	121.04	695.09
xxx-xx-6891	Kabrina	S	Smith	62,029.78	0.00	31,744.42	0.00	10,072.50	103,846.70
xxx-xx-6923	Myeka	L	Maiden	8,450.43	-2,000.00	1,010.96	0.00	1,683.53	9,144.92
xxx-xx-7044	Albert		Robinson Iii	1,822.95	0.00	2,255.64	0.00	29.78	4,108.37
xxx-xx-7110	Coleatha		Fowler	6,805.24	0.00	1,143.68	0.00	68.14	8,017.06
xxx-xx-7235	Latissa		Norman	5,504.83	0.00	6,655.95	-11,187.25	526.99	1,500.52
xxx-xx-7349	Jacqueline		Veal	571.10	0.00	1,946.77	0.00	17.08	2,534.95
xxx-xx-7499	Shaudelette	R	Nelson	18,445.59	0.00	10,064.94	0.00	4,296.70	32,807.23
xxx-xx-7697	Angela	M	Jenkins	2,533.52	0.00	2,173.40	0.00	35.98	4,742.90
xxx-xx-7699	Anthony	G	Basco	4,080.71	0.00	3,984.77	0.00	1,096.93	9,162.41
xxx-xx-7862	Gregory		Garner	21,448.58	0.00	24,392.17	0.00	5,778.23	51,618.98
xxx-xx-7966	Rayven		Forrest	2,259.58	0.00	0.00	-23.85	454.08	2,689.81
xxx-xx-8091	Andrea	D	Brown	0.00	0.00	750.00	0.00	2.39	752.39
xxx-xx-8231	Megan		Schafer	642.41	0.00	2,706.03	0.00	20.59	3,369.03
xxx-xx-8253	Michelle	L	McCalope	2,470.68	0.00	4,371.87	-7,601.29	758.74	0.00
xxx-xx-8266	Joy	K	Gradney	0.00	0.00	88.56	0.00	10.90	99.46
xxx-xx-8280	Lakisha	M	Honore	1,702.05	0.00	3,441.07	0.00	564.97	5,708.09
xxx-xx-8502	Gerianne		Pearson	2,509.88	0.00	0.00	-24.00	360.00	2,845.88
xxx-xx-8516	Nancy	D	Weeden	384.22	0.00	1,213.22	0.00	10.07	1,607.51
xxx-xx-8573	Donna	L	Jones	25.44	0.00	153.66	-91.70	16.64	104.04
xxx-xx-8619	Christina	G	Claiborne	106,604.33	0.00	16,828.38	0.00	10,167.83	133,600.54
xxx-xx-8679	Precious	S	Hutcherson	0.00	0.00	1,870.40	-10.38	133.66	1,993.68

xxx-xx-8698	Debreka		Duperclay	19.41	0.00	0.00	0.00		3.91	23.32
xxx-xx-8760	Courtney	T	Breaud	1,367.98	0.00	5,138.89	0.00		669.64	7,176.51
xxx-xx-8887	Elaine		Breaux	2,004.25	0.00	1,601.24	-23.71		526.60	4,108.38
xxx-xx-8957	Alexis	A	Smith	96.88	0.00	0.00	0.00		20.02	116.90
xxx-xx-9052	Trudi	N	Lewis	2,466.28	0.00	0.00	-24.00		488.81	2,931.09
xxx-xx-9183	Lonique		Travis	0.00	0.00	383.90	0.00		16.08	399.98
xxx-xx-9209	Monica		Hicks	1,386.29	0.00	3,411.05	-22.74		31.27	4,805.87
xxx-xx-9247	Emily		Fontenot	15,781.93	0.00	3,815.57	0.00		2,481.01	22,078.51
xxx-xx-9281	Deborah	P	Gooden	8,784.30	0.00	3,294.63	0.00		523.13	12,602.06
xxx-xx-9286	Erin		Kemp	590.99	0.00	521.32	-1,217.44		105.13	0.00
xxx-xx-9291	Alyss	R	Gilbeaux	26.30	0.00	1,225.88	-7.16		94.72	1,339.74
xxx-xx-9343	Gaynell	C	Banks	15,150.51	0.00	6,754.30	0.00		3,339.68	25,244.49
xxx-xx-9388	Kristen	G	Ambeau	659.07	0.00	743.16	-1,523.38		121.15	0.00
xxx-xx-9427	Barbara	A	Mouton	43,188.31	0.00	9,219.19	0.00		6,585.11	58,992.61
xxx-xx-9437	LaTasha	N	Perry	814.65	0.00	2,350.44	0.00		20.25	3,185.34
xxx-xx-9447	Uletta	S	Carter	1,368.52	0.00	1,402.17	-2,778.68		7.99	0.00
xxx-xx-9452	Adrienne	L	Bailey	0.00	0.00	1,358.80	-7.65		99.49	1,450.64
xxx-xx-9472	Pamela		Williams	576.37	0.00	0.00	-6.39		108.85	678.83
xxx-xx-9479	Tenisha		Murray	30.14	0.00	950.58	-1,071.88		91.16	0.00
xxx-xx-9501	Pamela	B	Daniel	41,916.73	0.00	11,690.00	0.00		6,811.66	60,418.39
xxx-xx-9615	Annie	H	Miller	41.19	0.00	0.00	0.00		0.41	41.60
xxx-xx-9616	Samantha		Hill	1,701.46	0.00	4,608.68	0.00		578.36	6,888.50
xxx-xx-9691	Donna	F	Matthews	43,036.55	0.00	7,336.45	0.00		6,867.20	57,240.20
xxx-xx-9697	Codie		Mcjulien	4,633.62	0.00	0.00	-24.00		932.96	5,542.58
xxx-xx-9842	Kiayra		Chapman	6,253.28	0.00	1,466.52	-24.00		1,345.30	9,041.10
xxx-xx-9856	Dominique	A	Landry	3,659.86	0.00	4,292.20	0.00		58.70	8,010.76
xxx-xx-9878	Temperance		Mitchell	8,508.74	0.00	1,705.36	-24.00		1,791.69	11,981.79
xxx-xx-9998	Stephanie	M	Harold	10,487.21	0.00	3,317.88	0.00		1,571.82	15,376.91
				1,391,477.69	-21,837.00	687,027.76	-52,913.44	0.00	237,069.51	2,240,824.52