

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110
1210-0089

2022

This Form is Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

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.**

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

- A** This return/report is for:
 - a multiemployer plan
 - a single-employer plan
 - a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
 - 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
 - special extension (enter description)
 - the DFVC program
- 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>BOBBIE NOONAN CHILD CARE GROUP INSURANCE PLAN</u>	1b Three-digit plan number (PN) ▶	<u>501</u>
	1c Effective date of plan	<u>01/01/2015</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>BOBBIE NOONANS CHILD CARE LLC</u> <u>8717 WEST LINCOLN HIGHWAY</u> <u>FRANKFORT, IL 60423</u>	2b Employer Identification Number (EIN)	<u>36-4161899</u>
	2c Plan Sponsor's telephone number	<u>815-469-2920</u>
	2d Business code (see instructions)	<u>624410</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.	<u>10/03/2023</u>	<u>JILL STOKES</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	<u>10/03/2023</u>	<u>JILL STOKES</u>
	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 (2022)
v. 220413

3a Plan administrator's name and address <input checked="" type="checkbox"/> 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 96																		
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).	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:75%;">6a(1) Total number of active participants at the beginning of the plan year</td> <td style="width:25%; text-align: right;">17</td> </tr> <tr> <td>6a(2) Total number of active participants at the end of the plan year</td> <td style="text-align: right;">0</td> </tr> <tr> <td>6b Retired or separated participants receiving benefits</td> <td style="text-align: right;">0</td> </tr> <tr> <td>6c Other retired or separated participants entitled to future benefits.....</td> <td style="text-align: right;">0</td> </tr> <tr> <td>6d Subtotal. Add lines 6a(2), 6b, and 6c.....</td> <td style="text-align: right;">0</td> </tr> <tr> <td>6e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.</td> <td></td> </tr> <tr> <td>6f Total. Add lines 6d and 6e</td> <td></td> </tr> <tr> <td>6g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....</td> <td></td> </tr> <tr> <td>6h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</td> <td></td> </tr> </table>	6a(1) Total number of active participants at the beginning of the plan year	17	6a(2) Total number of active participants at the end of the plan year	0	6b Retired or separated participants receiving benefits	0	6c Other retired or separated participants entitled to future benefits.....	0	6d Subtotal. Add lines 6a(2) , 6b , and 6c	0	6e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6f Total. Add lines 6d and 6e		6g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		6h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	
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6h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....																			
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: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4F 4H 4Q																			
9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> 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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> 1 A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> 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 2022 Form M-1 annual report. If the plan was not required to file the 2022 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 _____

(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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	(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	
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c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
▶		

(6) Total additions.....	7c(6)	
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d Total of balance and additions (add lines 7b and 7c(6))	7d	
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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)	
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	
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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 <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input checked="" type="checkbox"/> Life insurance |
| e <input checked="" type="checkbox"/> Temporary disability (accident and sickness) | f <input checked="" type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input checked="" type="checkbox"/> Other (specify) ▶ AD&D | | | |

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	16800
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	
Specify nature of costs.		

Part IV Provision of Information

- 11** Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No
- 12** If the answer to line 11 is "Yes," specify the information not provided. ▶

Electronic Filing Authorization for the 2022 Form 5500

Name of Plan: Bobbie Noonan Child Care Group Insurance Plan

Plan Year End: 12/31/2022

Part I Authorization of Practitioner to Electronically Sign and File

I hereby authorize our TPA to electronically sign and file the above-named return/reports through EFAST.

I understand that in granting this authority:

- I/We must manually **sign and date page 1 of Form 5500** and provide a scanned copy of that signature page to our TPA before the electronic filing can be initiated;
- Our TPA will retain a copy of this written authorization in its records;
- Our TPA will notify the individual(s) signing below as plan administrator/sponsor about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC as applicable regarding these annual return/reports; and
- A copy of my signature, as it appears on page 1 of the Form 5500, will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
- Our TPA shall not be deemed a Plan Administrator or other fiduciary with respect to the Plan solely on account of the services performed under this authorization

This authorization is applicable only to the filings for the above-named Plan and applies only for Plan year end stated above.

Plan Administrator / Sponsor



Date

10/3/23

Part II Acknowledgement of Receipt of Authorization

On behalf of your TPA, I hereby certify that the firm will use the authority granted only for the express purposes described above; that the firm will not disclose confidential information to any parties other than the DOL or IRS, as required for EFAST filing; and that the firm will take reasonable steps to assure that confidential information provided by the Plan Administrator or Plan Sponsor is protected from unauthorized disclosure.

The designated service provider must retain this authorization.

Do not submit this form to the DOL unless requested to do so.

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 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2022</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

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.)

B This return/report is: a single-employer plan; a DFE (specify) _____
 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 Bobbie Noonan Child Care Group Insurance Plan	1b Three-digit plan number (PN) ▶ 501
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) Bobbie Noonans Child Care LLC 8717 West Lincoln Highway US Frankfort IL 60423	1c Effective date of plan 01/01/2015 2b Employer Identification Number (EIN) 36-4161899 2c Plan Sponsor's telephone number (815) 469-2920 2d Business code (see instructions) 624410

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	<i>Jill R Stokes</i>	10/3/23	JILL R STOKES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Joe Noonan</i>	10/3/23	JOSEPH T. NOONAN
	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