

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 2022 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.)
	☐ 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 ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan 01/01/1983
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) ATLANTIC MEDICAL MANAGEMENT, LLC 118 MEMORIAL DRIVE JACKSONVILLE, NC 28546-6328	2b Employer Identification Number (EIN) 27-4374467
	2c Plan Sponsor's telephone number 980-999-2765
	2d Business code (see instructions) 621111

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.	10/12/2023	ZEN MENON
	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 (2022)
v. 220413

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		5 430
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) 275
a(2) Total number of active participants at the end of the plan year		6a(2) 293
b Retired or separated participants receiving benefits		6b 0
c Other retired or separated participants entitled to future benefits.....		6c 306
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d 599
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e 0
f Total. Add lines 6d and 6e		6f 599
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		6g 395
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		6h 133
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: 2E 2F 2G 2J 2K 2R 2T 3D 2X		
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) ☐ 0 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 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 _____

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
		2022
		This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022	
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC	D Employer Identification Number (EIN) 27-4374467

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

CHAPEL HILL INVESTMENT ANALYSTS

126 MATHEWS ST
SUITE 1600
GREENSBURG, PA 15601

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
26 27	INVESTMENT ADVISOR	52503	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALERUS FINANCIAL NA

ATTENTION TRUST OPERATIONS
PO BOX 64535
ST PAUL, MN 55164

(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?
15 19 37 99	INVESTMENT MGMT	13126	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KEYSTONE BENEFITS GROUP, INC.

314 OLD ROUTE 30
GREENSBURG, PA 15601

(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?
70	THIRD PARTY ADMINISTRATO	4316	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
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(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 2022 This Form is Open to Public Inspection.
	For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022	

A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN		B Three-digit plan number (PN) ►	001
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC		D Employer Identification Number (EIN) 27-4374467	

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: CAPITAL PRESERVATION FUND			
b Name of sponsor of entity listed in (a): PUTNAM STABLE VALUE FUND			
c EIN-PN 22-2712853-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1948081	
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
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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
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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 2022 This Form is Open to Public Inspection				
For calendar plan year 2022 or fiscal plan year beginning <u>01/01/2022</u> and ending <u>12/31/2022</u>						
A Name of plan <u>ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 5px;"> B Three-digit plan number (PN) ► </td> <td style="width: 20%; padding: 5px; text-align: center;"> 001 </td> </tr> <tr> <td colspan="2" style="height: 20px;"></td> </tr> </table>		B Three-digit plan number (PN) ►	001		
B Three-digit plan number (PN) ►	001					
C Plan sponsor's name as shown on line 2a of Form 5500 <u>ATLANTIC MEDICAL MANAGEMENT, LLC</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 5px;"> D Employer Identification Number (EIN) <u>27-4374467</u> </td> <td style="width: 20%;"></td> </tr> </table>		D Employer Identification Number (EIN) <u>27-4374467</u>			
D Employer Identification Number (EIN) <u>27-4374467</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	024404
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....		1b(1)	5516471044430
(2) Participant contributions.....		1b(2)	1995197444
(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)	8794786300
(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)	1348416113829140
(14) Value of funds held in insurance company general account (unallocated contracts).....		1c(14)	
(15) Other		1c(15)	

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(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	14143706	15081718

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	0	307770
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	307770

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	14143706	14773948
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	807561	
(B) Participants	2a(1)(B)	708424	
(C) Others (including rollovers)	2a(1)(C)	597188	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		2113173
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)	3772	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		3772
(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)	357423	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		357423
(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)		-2363365
(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		111003
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	316536	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		316536
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		15435
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	74971	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		74971
j Total expenses. Add all expense amounts in column (b) and enter total	2j		406942
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		-295939
l Transfers of assets:			
(1) To this plan	2l(1)		926181
(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: LALLY & CO

(2) EIN: 25-1846963

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		50947

	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?	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
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.)	X		
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 2022 This Form is Open to Public Inspection.
For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022		
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN		B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC		D Employer Identification Number (EIN) 27-4374467
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): 45-6062081		
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) 2022 v. 220413		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

14	Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:		
	a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ last contributing employer ☐ alternative ☐ reasonable approximation (see instructions for required attachment).....	14a	
	b The plan year immediately preceding the current plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	14b	
	c The second preceding plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	14c	
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:		
	a The corresponding number for the plan year immediately preceding the current plan year.....	15a	
	b The corresponding number for the second preceding plan year.....	15b	
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:		
	a Enter the number of employers who withdrew during the preceding plan year	16a	
	b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....	16b	
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐		

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

**ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN**

**FINANCIAL STATEMENTS
AND
SUPPLEMENTAL SCHEDULES**

DECEMBER 31, 2022 AND 2021



Lally & Co.

CPAs and Business Advisors

**ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
FINANCIAL STATEMENTS
AND
SUPPLEMENTAL SCHEDULES
DECEMBER 31, 2022 AND 2021**

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Lally & Co.

CPAs and Business Advisors

INDEPENDENT AUDITORS' REPORT

To the Trustees
Atlantic Medical Management, LLC 401(k) Profit Sharing Plan
Jacksonville, North Carolina

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

We have performed audits of the financial statements of the **Atlantic Medical Management, LLC 401(k) Profit Sharing Plan** ("Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as permitted by ERISA Section 103(a)(3)(C). The financial statements comprise the statements of net assets available for benefits as of December 31, 2022 and 2021, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of the Plan'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 ("DOL") 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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from a qualified institution as of December 31, 2022 and 2021 and for the years then ended, 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 Auditors' Responsibilities for the Audit of the Financial Statements section of our report:

- The amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with U.S. generally accepted accounting principles ("GAAP").
- The information in the accompanying financial statements 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 U.S. generally accepted auditing standards (“GAAS”). Our responsibilities under those standards are further described in the Auditors’ Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan 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 GAAP, 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 the Plan’s ability to continue as a going concern for one year after the date that the financial statements are 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.

Auditors’ 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 auditors’ 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 GAAS 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 could reasonably be expected to influence the economic decisions of users made on the basis of these financial statements

In performing an audit in accordance with GAAS, 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 the Plan'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 the Plan'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 GAAP.

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 GAAP.

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.

Other Matter — Supplemental Schedules Required by ERISA

The supplemental schedule of assets (held at end of year) and schedule of delinquent participant contributions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the DOL'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 U.S. generally accepted auditing standards ("GAAS"). For information included in the supplemental schedules that is 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 DOL'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 are agreed to or is derived from the certified investment information, are presented, in all material respects, in conformity with the DOL'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).

Lally & Co, LLC

Pittsburgh, Pennsylvania
October 9, 2023

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2022 AND 2021

	<u>2022</u>	<u>2021</u>
ASSETS		
Investments		
Investments at Fair Value	<u>\$ 13,829,140</u>	<u>\$ 13,484,161</u>
Receivables		
Participant Contributions	97,444	19,951
Employer Contributions	1,044,430	551,647
Notes Receivable From Participants	<u>86,300</u>	<u>87,947</u>
Total Receivables	<u>1,228,174</u>	<u>659,545</u>
Cash and Cash Equivalents	<u>24,404</u>	<u>106,935</u>
Total Assets	15,081,718	14,250,641
LIABILITIES		
Due to Broker for Purchase of Investments	<u>307,770</u>	<u>106,935</u>
Net Assets Available for Benefits	<u><u>\$ 14,773,948</u></u>	<u><u>\$ 14,143,706</u></u>

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

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEARS ENDED DECEMBER 31, 2022 AND 2021

ADDITIONS	2022	2021
Additions To Net Assets Attributed to Investment Income		
Net Appreciation in Fair Value of Investments	\$ -	\$ 1,158,593
Dividends and Interest	357,423	624,558
Total Investment Income	<u>357,423</u>	<u>1,783,151</u>
Interest Income on Notes Receivable From Participants	<u>3,772</u>	<u>6,357</u>
Contributions		
Participant	708,424	478,649
Employer	807,561	551,647
Rollover	597,188	-
Total Contributions	<u>2,113,173</u>	<u>1,030,296</u>
Total Additions	<u>2,474,368</u>	<u>2,819,804</u>
DEDUCTIONS		
Deductions From Net Assets Attributed to		
Net Depreciation in Fair Value of Investments	2,363,365	-
Benefits Paid to Participants	331,971	344,598
Administrative Expenses	74,971	79,319
Total Deductions	<u>2,770,307</u>	<u>423,917</u>
Net Increase (Decrease)	(295,939)	2,395,887
Net Assets Transferred Into the Plan - Note 1	926,181	-
Net Assets Available for Benefits		
Beginning of Year	<u>14,143,706</u>	<u>11,747,819</u>
End of Year	<u><u>\$ 14,773,948</u></u>	<u><u>\$ 14,143,706</u></u>

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

**ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS**

1 - DESCRIPTION OF PLAN

The following description of the Atlantic Medical Management, LLC 401(k) Profit Sharing Plan ("Plan") provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution plan covering all full-time employees of Atlantic Medical Management, LLC, and Jacksonville Children's and Multispecialty Clinic, P.A., as well as commonly owned entities indicated below ("Company"), with the exception of non-resident aliens, independent contractors, and those covered by a collective bargaining agreement. Employees become eligible to make deferrals and receive related matching contributions once they have attained age 21 and have completed 300 hours of service during a three (3) month period, measured from their hire date, or successive three (3) month periods up until they complete 1,000 hours of service as defined in the Plan document. Plan entry dates are the first day of the month coinciding with or following the date the eligibility requirements are met.

Effective May 1, 2022, CCNC MM, LLC and Coastal Carolina Neuropsychiatric Center, P.A., commonly owned entities, adopted the Plan. Accordingly, plan assets and liabilities of plans that were previously sponsored by these entities were transferred into the Plan.

Contributions

Plan participants may contribute to the Plan under a salary deferral arrangement. An eligible participant may elect to contribute up to 85% of pre-tax compensation to the Plan. Contributions are subject to certain Internal Revenue Code ("IRC") limitations. In addition, in any calendar year in which a participant is age 50 or above, an additional catch-up contribution may be made. The Plan also permits rollover contributions of retirement benefits received from other qualified plans and roth elective deferrals.

The Company has elected safe harbor nondiscrimination rules under the IRC and provides a non-elective contribution of 3% to the Plan based on eligible participant compensation.

The Company may provide discretionary matching and profit-sharing contributions as determined by the Company's Board of Directors. Profit sharing contributions are allocated to participants based on their compensation as defined in the Plan document. Participants must be employed on the last day of the Plan year and have completed 1,000 hours of service to receive the discretionary matching contribution. There are no requirements for participants to be eligible to receive the discretionary profit sharing contributions.

The Company made a discretionary profit sharing contribution amounting to approximately \$180,000 and \$237,000 in 2022 and 2021, respectively. The Company did not make any matching contributions in 2022 or 2021.

Participant Accounts

Participants direct the investment of their contributions and the Company's contributions into various investment options offered by the Plan.

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

1 - DESCRIPTION OF PLAN (CONTINUED)

Participant Accounts (Continued)

Each participant's account is credited with their contributions, Company matching contributions, allocations of safe harbor contributions, discretionary profit sharing contributions, and earnings thereon. Participant accounts are charged with an allocation of administrative expenses that are paid by the Plan. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting

Participants are immediately vested in their contributions, safe harbor contributions, plus earnings thereon. Vesting in the Company's discretionary contributions, and earnings thereon are based on a five (5) year vesting schedule at 20% per year beginning upon completion of two (2) years of service.

Notes Receivable From Participants

Participants may request a loan from the Plan. The maximum amount that participants may borrow is equal to the lesser of \$50,000 or one-half of their vested account balance. A participant may have two (2) loans outstanding at any time. Repayment terms generally may not exceed 5 years. Participant loans currently bear interest ranging from 4.25% to 8.50%. Participant loans are collateralized by the participant's vested account balance.

Payment of Benefits

Upon termination of service due to retirement, death, or other reasons, the participant's vested benefit is to be distributed in a manner, as defined in the plan document, chosen by the participant or beneficiary. If the participant's vested account balance is \$1,000 or less, payment is to be paid in a single sum. A terminated participant may also elect to retain their vested account balance with the Plan until required to take mandatory distributions at age 70½.

Normal retirement age is 65; however, an active employee may begin to receive benefits at age 59½.

Forfeited Accounts

Forfeited balances of terminated participant's non-vested accounts may be used to reduce plan expenses or used to reduce the Company's contributions to the Plan. At December 31, 2022 and 2021, forfeited non-vested accounts were not significant.

Basis of Presentation

The financial statements of the Plan are prepared on the accrual basis of accounting and are prepared in conformity with U.S. generally accepted accounting principles ("GAAP") as promulgated by the Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC").

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

2 - SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that may affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reported period. Actual results could differ from those estimates.

Cash and Cash Equivalents

The Plan considers all short-term investments with initial maturities of three months or less to be cash equivalents. The Plan places its temporary cash investments with high credit quality financial institutions. At times, such investments may be in excess of the Federal Deposit Insurance Corporation ("FDIC") insurance limit. The Plan has not experienced any losses in such accounts.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's management determines the Plan's valuation policies utilizing information provided by the investment advisors, the custodian, and the trustees of the Plan.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation or depreciation in fair value of investments includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Notes Receivable From Participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expenses when they are incurred. No allowance for credit losses has been recorded as of December 31, 2022 and 2021.

Benefit Payments

Benefits payments are recorded when paid.

Administration Expenses

Certain expenses of maintaining the Plan are paid by the Plan, unless otherwise paid by the Company. Expenses that are paid by the Company are excluded from these financial statements. Investment related expenses are included in net appreciation or depreciation in fair value of investments.

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

3 - FAIR VALUE MEASUREMENTS

Fair Value Hierarchy

FASB ASC defines fair value, establishes a framework for measuring fair value, and establishes a fair value hierarchy which prioritizes the inputs to valuation techniques. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction to sell the asset or transfer the liability which occurs in the principal market for the asset or liability or, in the absence of a principal market, the most advantageous market. Valuation techniques that are consistent with the market, income or cost approach, as specified by FASB ASC, are used to measure fair value.

The fair value hierarchy prioritizes the inputs to valuation techniques used to measure fair value into three broad levels:

- Level 1: Valuations based on unadjusted quoted prices available in active markets for identical assets or liabilities. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these securities does not entail a significant degree of judgment.
- Level 2: Valuations based on quoted prices for similar assets in active or inactive markets, inputs other than quoted prices that are observable, or inputs that are derived principally from or corroborated by observable market data by correlation or other means.
- Level 3: Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from security to security and is affected by a wide variety of factors, including, for example, the type of security, the liquidity of markets, and other characteristics particular to the security. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment. Accordingly, the degree of judgment exercised in determining fair value is greatest for instruments categorized in Level 3.

The inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, for disclosure purposes, the level in the fair value hierarchy within which the fair value measurement falls in its entirety is determined based on the lowest level input that is significant to the fair value measurement in its entirety.

Processes and Structure

Management is responsible for the Plan's fair value valuation policies, processes, and procedures. These control processes are designed to assure that the values used for financial reporting are based on observable inputs wherever possible. In the event that observable inputs are not available, the control processes are designed to assure that the valuation approach utilized is appropriate and consistently applied and that the assumptions are reasonable.

Fair Value Measurements

Fair value is a market-based measure considered from the perspective of a market participant rather than an entity-specific measure. Therefore, even when market assumptions are not readily available, the Plan's own assumptions are set to reflect those that the Plan believes market participants would use in pricing the asset or liability at the measurement date.

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

3 - FAIR VALUE MEASUREMENTS (CONTINUED)

Fair Value Measurements (Continued)

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in methodologies used at December 31, 2022 and 2021.

Self-directed Brokerage Accounts: Accounts primarily consist of mutual funds that are valued on the basis of readily determinable market prices.

Mutual Funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-ended mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Stable Value Fund: The Putnam Stable Value Fund, held in a collective trust fund, is comprised of fully benefit-responsive investment contracts, and is valued at the NAV of units of the collective trust. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported NAV. Participant transactions (purchases and sales) may occur daily. Were the Plan to initiate a full redemption of the collective trust, the issuer reserves the right to temporarily delay withdrawal from the trust in order to ensure that securities liquidations will be carried out in an orderly business manner.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table summarizes the valuation of the Plan's investments by fair value hierarchy as described above as of:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
<u>December 31, 2022:</u>				
Self-Directed Brokerage				
Accounts	\$ 2,428,718	\$ -	\$ -	\$ 2,428,718
Mutual Funds	<u>9,452,341</u>	<u>-</u>	<u>-</u>	<u>9,452,341</u>
Total Assets in the Fair Value				
Hierarchy	<u>\$ 11,881,059</u>	<u>\$ -</u>	<u>\$ -</u>	11,881,059
Investments Measured at Net				
Asset Value				<u>1,948,081</u>
Investments at Fair Value				<u>\$ 13,829,140</u>

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

3 - FAIR VALUE MEASUREMENTS (CONTINUED)

Fair Value Measurements (Continued)

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
<u>December 31, 2021:</u>				
Self-Directed Brokerage				
Accounts	\$ 579,529	\$ -	\$ -	\$ 579,529
Mutual Funds	<u>10,911,795</u>	<u>-</u>	<u>-</u>	<u>10,911,795</u>
Total Assets in the Fair Value Hierarchy	<u>\$ 11,491,324</u>	<u>\$ -</u>	<u>\$ -</u>	11,491,324
Investments Measured at Net Asset Value				<u>1,992,837</u>
Investments at Fair Value				<u>\$ 13,484,161</u>

Investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value of investments in the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

The Plan's investments (including gains and losses on investments bought and sold, as well as held during the year) depreciated in value by approximately \$2.4 million in 2022 and appreciated in value by approximately \$1.2 million 2021.

Fair Value of Investments in Entities That Use NAV

The following table summarizes investments measures at fair value based on NAV per share as of:

	<u>Fair Value</u>	<u>Unfunded Commitments</u>	<u>Redemption Frequency (if currently eligible)</u>	<u>Redemption Notice Period</u>
<u>December 31, 2022:</u>				
Putnam Stable Value Fund	\$1,948,081	N/A	Daily	N/A
<u>December 31, 2021:</u>				
Putnam Stable Value Fund	\$1,992,837	N/A	Daily	N/A

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

4 - CERTIFICATION OF FINANCIAL INFORMATION

Alerus Financial, N.A., the custodian of the Plan, has certified that the following investment information included in the accompanying financial statements and supplemental schedule is complete and accurate:

- Investments as shown in the statements of net assets available for plan benefits as of December 31, 2022 and 2021.
- Investment income as shown in the statements of changes in net assets available for plan benefits for the years ended December 31, 2022 and 2021.
- Investment information included in the schedule of assets (held at end of year) as of December 31, 2022, as shown on the supplemental schedule.

The Plan's independent auditors did not perform auditing procedures with respect to this certified investment information, except for comparing such information with the related investment information included in the financial statements and supplemental schedule.

5 - PLAN TERMINATION

Although it has not expressed any intent to do so, the Company has the right under the Plan to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants would become 100% vested in their accounts. Any unallocated assets of the Plan will be allocated to participant accounts and distributed in such manner as the Company may determine.

6 - TAX STATUS

The underlying pre-approved plan provider received an opinion letter from the Internal Revenue Service ("IRS") dated June 30, 2020, stating that the form of the Plan is qualified under Section 401 of the IRC. In accordance with IRS pronouncements, the Company has determined that it is eligible to, and has chosen to, rely on the current IRS opinion letter. Once qualified, the Plan is required to operate in conformity with the IRC to maintain its tax-exempt status. The Plan has been amended since receiving the opinion letter. The plan administrator believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC. Therefore, no provision for income taxes has been included in the Plan's financial statements.

GAAP prescribes rules for the recognition, measurement, classification, and disclosure in the financial statements of uncertain tax positions taken or expected to be taken in the Plan's tax returns. Management has determined that the Plan does not have any uncertain tax positions and associated unrecognized tax benefits that materially impact the financial statements or related disclosures. Since tax matters are subject to some degree of uncertainty, there can be no assurance that the Plan's tax returns will not be challenged by the taxing authorities and that the Plan will not be subject to additional tax, penalties, and interest as a result of such a challenge. Generally, the Plan's federal returns remain open for income tax examination for three years from date of filing.

ATLANTIC MEDICAL MANAGEMENT, LLC
401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
(CONTINUED)

7 - RISKS AND UNCERTAINTIES

The Plan invests in various types of 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 values of investment securities will occur in the near term and that such changes could materially affect the participant's account balances and the amounts reported in the statements of net assets available for benefits.

8 - RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS

Certain Plan investments are managed by Alerus Financial N.A., which is the custodian under the Plan, and therefore, these transactions qualify as party-in-interest transactions. Fees incurred by the Plan for investment management services are included in net appreciation or depreciation in fair value of investments, as they are paid through revenue sharing, rather than a direct payment.

9 - DELINQUENT PARTICIPANT CONTRIBUTIONS

The Company failed to timely remit employee deferrals to the Plan in the amount of \$50,947. These deferrals were remitted to the Plan. The Company has computed the lost earnings on these deposits and will make a contribution for lost earnings to the Plan during the 2023 plan year.

10 - SUBSEQUENT EVENTS

The accompanying financial statements include an evaluation of events or transactions that have occurred after December 31, 2022 and through October 9, 2023, the date the financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES

ATLANTIC MEDICAL MANAGEMENT, LLC

401(k) PROFIT SHARING PLAN

EIN: 27-4374467

PLAN NUMBER: 001

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS HELD (HELD AT END OF YEAR)

DECEMBER 31, 2022

(a)	(b)	(c)	(d)	(e)
Identity of Party Involved	Identity of Issuer, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Cost	Current Value
	American Funds	EuroPacific Growth Fund R5	\$ **	\$ 994,771
	American Funds	Capital World Growth & Income Fund R5	**	40,952
	American Funds	The Growth Fund of America R5	**	436,654
	American Funds	American High-Income Trust Fund R5	**	8,287
	American Funds	Investment Company of America R5	**	3,493
	American Funds	New World Fund R5	**	357,069
	American Funds	Small Cap World R5	**	2
	American Funds	Balanced Fund R5	**	38,426
	American Funds	New Perspective Fund	**	30,303
	Vanguard	Income Fund	**	675,969
	Vanguard	Explorer Fund	**	288,463
	Vanguard	Growth Index Fund	**	225,807
	Vanguard	Index Trust 500 Portfolio Fund	**	2,488,366
	Vanguard	Index Trust Mid-Cap Index Fund	**	837,547
	Vanguard	Inflation Protected Secs Adm Class Fund	**	772,396
	Vanguard	Information Tech and Adm Fund	**	666,587
	Vanguard	Long Term Investment Grade Fund	**	5,871
	Vanguard	Mid Cap Growth Fund	**	1,491
	Vanguard	REIT Index Fund	**	234,707
	Vanguard	Target Retirement 2025 Fund	**	271,087
	Vanguard	Target Retirement 2035 Fund	**	69,653
	Vanguard	Target Retirement 2045 Fund	**	185,115
	Vanguard	Target Retirement 2055 Fund	**	116,456
	Vanguard	Target Retirement Income	**	3,607
	Dimensional	US Large Cap Value Fund	**	70,281
	Dimensional	US Micro Cap Fund	**	31,945
	Dimensional	US Small Cap Value	**	15,312
	Pimco	Total Return Institutional Fund	**	292,624
	Pimco	Real Return Institutional Fund	**	289,100
	Putnam	Stable Value Fund	**	1,948,081
***	TD Ameritrade	TD Ameritrade Brokerage	**	2,428,718
*	Participant Loans	Due 12/2026; Interest Rate - 4.25% - 8.50%	**	86,300
			<u>\$ -</u>	<u>\$ 13,915,440</u>
*	Party-in-interest			
**	Cost omitted for participant directed investments			
***	Participant-directed brokerage accounts reported in aggregate			

See independent auditors' report.

ATLANTIC MEDICAL MANAGEMENT, LLC
 401(k) PROFIT SHARING PLAN
 EIN: 27-4374467
 PLAN NUMBER: 001
**SCHEDULE H, LINE 4a - SCHEDULE OF DELINQUENT PARTICIPANT
 CONTRIBUTIONS**
YEAR ENDED DECEMBER 31, 2022

Participant Contributions Transferred Late to Plan	Check here if Late Participant Loan Repayments are included	Total That Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002-51
		Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
\$ 50,947		\$ 50,947	\$ -	\$ -	\$ -

See independent auditors' report.

Multiple Employer Plan Participating Employer Information

Atlantic Medical Management, LLC 401(k) Profit Sharing Plan, EIN 27-4374467, PN 001

Atlantic Medical Management, LLC	27-4374467	75%	\$12,857.002
Coastal Carolina Neuropsychiatric Center, P.A.	20-5374475	25%	\$1,052,160

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 2022 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 single-employer plan B This return/report is: ☐ the first return/report ☐ an amended return/report ☐ the final return/report ☐ a short plan year return/report (less than 12 months)	☒ 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) _____ C If the plan is a collectively-bargained plan, check here. ☐ D Check box if filing under: ☒ Form 5558 ☐ special extension (enter description) ☐ automatic extension ☐ 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 ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN 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) ATLANTIC MEDICAL MANAGEMENT, LLC 118 MEMORIAL DRIVE JACKSONVILLE NC 28546-6328	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;">001</td> </tr> <tr> <td colspan="2">1c Effective date of plan 01/01/1983</td> </tr> <tr> <td colspan="2">2b Employer Identification Number (EIN) 27-4374467</td> </tr> <tr> <td colspan="2">2c Plan Sponsor's telephone number 980-999-2765</td> </tr> <tr> <td colspan="2">2d Business code (see instructions) 621111</td> </tr> </table>	1b Three-digit plan number (PN) ▶	001	1c Effective date of plan 01/01/1983		2b Employer Identification Number (EIN) 27-4374467		2c Plan Sponsor's telephone number 980-999-2765		2d Business code (see instructions) 621111	
1b Three-digit plan number (PN) ▶	001										
1c Effective date of plan 01/01/1983											
2b Employer Identification Number (EIN) 27-4374467											
2c Plan Sponsor's telephone number 980-999-2765											
2d Business code (see instructions) 621111											

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	 Signature of plan administrator	10/11/23 Date	ZEN MENON 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 (2022)
v. 220413

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	430
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)	275
a(2) Total number of active participants at the end of the plan year		6a(2)	293
b Retired or separated participants receiving benefits		6b	0
c Other retired or separated participants entitled to future benefits		6c	306
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	599
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	0
f Total. Add lines 6d and 6e		6f	599
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g	395
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		6h	133
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: 2E 2F 2G 2J 2K 2R 2T 3D 2X			
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) ☐ 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 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 _____

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
		2022
		This Form is Open to Public Inspection.
For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022		
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC		D Employer Identification Number (EIN) 27 - 4374467

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

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(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)

CHAPEL HILL INVESTMENT ANALYSTS
126 MATHEWS ST
SUITE 1600
GREENSBURG PA 15601

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
26 27	INVESTMENT ADVISOR	52,503	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALERUS FINANCIAL NA
ATTENTION TRUST OPERATIONS
PO BOX 64535
ST PAUL MN 55164

(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?
15 19 37 99	INVESTMENT MGMT	13,126	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KEYSTONE BENEFITS GROUP, INC.
314 OLD ROUTE 30
GREENSBURG PA 15601

(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?
70	THIRD PARTY ADMINISTRATO	4,316	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)
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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 2022 This Form is Open to Public Inspection.	
For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022					
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN			B Three-digit plan number (PN) ▶		001
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC			D Employer Identification Number (EIN) 27-4374467		
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:Capital Preservation Fund					
b Name of sponsor of entity listed in (a):Putnam Stable Value Fund					
c EIN-PN 22-2712853 001		d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1,948,081		
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) 2022 v. 220413

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 2022 This Form is Open to Public Inspection
For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022		
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN		B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC		D Employer Identification Number (EIN) 27-4374467

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	0	24,404
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	551,647	1,044,430
(2) Participant contributions.....	1b(2)	19,951	97,444
(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)	87,947	86,300
(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)	13,484,161	13,829,140
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(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	14,143,706	15,081,718

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	0	307,770
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	0	307,770

Net Assets

l Net assets (subtract line 1k from line 1f).....	1l	14,143,706	14,773,948
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	807,561	
(B) Participants	2a(1)(B)	708,424	
(C) Others (including rollovers).....	2a(1)(C)	597,188	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		2,113,173
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)	3,772	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		3,772
(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)	357,423	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		357,423
(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)		-2,363,365
(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		111,003
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	316,536	
(2) To insurance carriers for the provision of benefits.....	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		316,536
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		15,435
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees.....	2i(1)	74,971	
(2) Contract administrator fees.....	2i(2)		
(3) Investment advisory and management fees.....	2i(3)		
(4) Other.....	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		74,971
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		406,942
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d.....	2k		-295,939
l Transfers of assets:			
(1) To this plan.....	2l(1)		926,181
(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: LALLY & CO

(2) EIN: 25-1846963

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		50,947

	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.)		X	
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.)		X	
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.)		X	
4d		X	
e Was this plan covered by a fidelity bond?	X		500,000
4e	X		500,000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
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?		X	
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?		X	
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.)	X		
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.)		X	
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?		X	
4k		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
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 H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan:

► Atlantic Medical Management, LLC 401(k)

Employer Identification Number: ► 27-4374467

For plan year (beginning/ending): ► 1/1/2022 - 12/31/2022

Plan number: ► 001

(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
*	Alerus Financial Services, NA.	AF NEW WORLD R5		357,069
*	Alerus Financial Services, NA.	AMER CAP WRLD GRW & INC R5		40,952
*	Alerus Financial Services, NA.	AMERICAN BALANCED R-5		38,426
*	Alerus Financial Services, NA.	AMERICAN HIGH INCOME R5		8,287
*	Alerus Financial Services, NA.	DFA US LRG CAP VALUE		70,281
*	Alerus Financial Services, NA.	DFA US MICRO CAP		31,945
*	Alerus Financial Services, NA.	DFA US SMALL CAP VALUE		15,312
*	Alerus Financial Services, NA.	EUROPACIFIC GROWTH FUND R-5		994,771
*	Alerus Financial Services, NA.	GROWTH FUND OF AMERICAN R-5		436,654
*	Alerus Financial Services, NA.	INVESTMENT CO AMERICA R5		3,493
*	Alerus Financial Services, NA.	NEW PERSPECTIVE FUND R-5		30,303
*	Alerus Financial Services, NA.	PIMCO REAL RETURN INSTL		289,100
*	Alerus Financial Services, NA.	PIMCO TOTAL RETURN INSTL		292,624
*	Alerus Financial Services, NA.	PUTNAM STABLE VALUE FUND: 25BP		1,948,083
*	Alerus Financial Services, NA.	SMALLCAP WORLD FUND R5		2
*	Alerus Financial Services, NA.	SELF DIRECTED FUND		2,428,718
*	Alerus Financial Services, NA.	VANGUARD 500 INDEX		2,488,364
*	Alerus Financial Services, NA.	VANGUARD EQUITY INCOME		675,969
*	Alerus Financial Services, NA.	VANGUARD EXPLORER FUND		288,463
*	Alerus Financial Services, NA.	VANGUARD GROWTH INDEX		225,807
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*	Alerus Financial Services, NA.	VANGUARD INFORMATION TECHNOLOG		666,587
*	Alerus Financial Services, NA.	VANGUARD LONG-TERM CORP FUND		5,871
*	Alerus Financial Services, NA.	VANGUARD MID CAP GROWTH FUND		1,491
*	Alerus Financial Services, NA.	VANGUARD MID CAP INDEX ADMIRAL		837,547
*	Alerus Financial Services, NA.	VANGUARD REAL ESTATE INDEX		234,707
*	Alerus Financial Services, NA.	VANGUARD TARGET RETIREMENT INC		3,607
*	Alerus Financial Services, NA.	VANGUARD TARGET RETIREMENT2025		271,087
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*	Alerus Financial Services, NA.	VANGUARD TARGET RETIREMENT2045		185,115
*	Alerus Financial Services, NA.	VANGUARD TARGET RETIREMENT2055		116,456
*	Alerus Financial Services, NA.	LOAN FUND		83,539
*	Alerus Financial Services, NA.	DEEMED LOAN FUND		2,761

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 2022 This Form is Open to Public Inspection.			
For calendar plan year 2022 or fiscal plan year beginning		01/01/2022		and ending		12/31/2022	
A Name of plan ATLANTIC MEDICAL MANAGEMENT, LLC 401(K) PROFIT SHARING PLAN				B Three-digit plan number (PN) ▶		001	
C Plan sponsor's name as shown on line 2a of Form 5500 ATLANTIC MEDICAL MANAGEMENT, LLC				D Employer Identification Number (EIN) 27-4374467			
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): 45-6062081 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)? If the plan is a defined benefit plan, go to line 8.				☐ Yes		☐ No	
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.				☐ N/A			
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	
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	
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) 2022 v. 220413			

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents)

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents)

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents)

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents)

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a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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(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 _____

Schedule H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan:

► Atlantic Medical Management, LLC 401(k)

Employer Identification Number: ► 27-4374467

For plan year (beginning/ending): ► 1/1/2022 - 12/31/2022

Plan number: ► 001

(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
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*	Alerus Financial Services, NA.	GROWTH FUND OF AMERICAN R-5		436,654
*	Alerus Financial Services, NA.	INVESTMENT CO AMERICA R5		3,493
*	Alerus Financial Services, NA.	NEW PERSPECTIVE FUND R-5		30,303
*	Alerus Financial Services, NA.	PIMCO REAL RETURN INSTL		289,100
*	Alerus Financial Services, NA.	PIMCO TOTAL RETURN INSTL		292,624
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