Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed 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-SF.**

OMB Nos. 1210-0110
1210-0089

2022

This Form is Open to Public Inspection

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: [X] a single-employer plan [ ] a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)

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 Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] DFVC program
[ ] special extension (enter description)

D 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
MID-IOWA FAMILY THERAPY CLINIC BENEFITS PLAN

1b Three-digit plan number (PN) ▸ 501

1c Effective date of plan 01/01/2009

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)

CHRISTINE SECRIST

20244 141ST ST
PERRY, IA 50220-6302

20244 141ST ST
PERRY, IA 50220-6302

2b Employer Identification Number (EIN) 42-1375607

2c Sponsor's telephone number

2d Business code (see instructions) 624100

3a Plan administrator's name and address [X] Same as Plan Sponsor.

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.
a Sponsor's name
c Plan Name

4b EIN

4d PN

Item	Description	Line	Value
5a	Total number of participants at the beginning of the plan year	5a	52
b	Total number of participants at the end of the plan year	5b	48
c	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c	0
d(1)	Total number of active participants at the beginning of the plan year	5d(1)	52
d(2)	Total number of active participants at the end of the plan year	5d(2)	48
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0

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, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.	10/14/2023	CHRISTINE SECRIST
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2023	CHRISTINE SECRIST
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) [X] Yes [ ] No

b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) [X] Yes [ ] No

If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? [ ] Yes [ ] No [X] Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year______________________. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	0	0
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	0	0
8 Income, Expenses, and Transfers for this Plan Year		**(a) Amount**	**(b) Total**
a Contributions received or receivable from: (1) Employers	8a(1)	765525	
(2) Participants	8a(2)	147930	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	0	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		913455
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	842130	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	44957	
g Other expenses	8g	26368	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		913455
i Net income (loss) (subtract line 8h from line 8c)	8i		0
j Transfers to (from) the plan (see instructions)	8j	0	

Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:
4A 4B 4D 4E 4H

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		500000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e	X		44957
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below. ☐ Yes ☒ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

b **PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than $0, 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 ______

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

a 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 letter ruling granting the waiver. Month ______ Day ______ Year ______

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year	**12b**	
c Enter the amount contributed by the employer to the plan for this plan year	**12c**	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	**12d**	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?	☐ Yes ☐ No ☐ N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☐ Yes ☒ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

c 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.)

13c(1) Name of plan(s):	**13c(2)** EIN(s)	**13c(3)** PN(s)

Insurance Data for Schedule A Form 5500

Group #60790-6273
Insurance Carrier: Fidelity Security Life Insurance Company
Carrier NAIC Code No.: 71870 Carrier EIN: 43-0949844
Administrator: Avesis Third Party Administrators, Inc. Benefit Type: Vision Care
Policy or Contract Period: 4/01/2022 – 3/31/2023 Organization Code: 5

Group Legal Name and Address:
Mid Iowa Family Therapy Clinic
20244 141st Street
Perry, IA 50220

Approximate Number of Persons Covered at the end of policy or contract period: 109 (82 employees)

Premium:

EE	$ 6.82	EE & Dep	$ 11.93
EE & Ch	$ 14.32	EE & Family	$ 17.72

Total Premium Paid to Carrier	$ 8,059.15
Commissions Paid for Contract Year:	
Select Networks 317 6th Avenue, Suite 1440 Des Moines, IA 50309	$ 886.50
Mutual Med Insurance Services 4321 East 60th Street Davenport, IA 52807	$ 805.92
Total Commissions	$1,692.42

"Total Premium Paid to Carrier" listed above may differ from your records due to timing of posting payments, timing of employee payroll changes and our internal business practices related to the application of premium. For this reason, we suggest you use your Accounts Payable or Payroll Records for reporting "Premium Paid to Carrier."

Avesis hereby certifies that this statement is furnished pursuant to 29 CFR 2520.103-5 (c) and is complete and accurate as of 5/18/2023.

	Bob Powers	sb
NAME	Mid Iowa Family Therapy Clinic	
	20244 141 St. PO Box 416	
ADDRESS	Perry, IA 50220	
EIN	42-1375607	

The following information is provided to help with the filing of the 5500 information.

Plan Year: 04/01/2022-03/31/2023

Group No. 1904

Approximate number of persons covered at beginning of year: 54

Approximate number of persons covered at end of year: 48

Stoploss:	Carrier	Sirius American Insurance Co	
	EIN Number	13-2930697	
	NAIC Code	35408	
	Contract #	1904	
	Premium	$ 134,162.20	
Agent/Broker	Paradigm Benefits 218 1st Street SW Clarion, IA 50525-1407	28,311.00	Commission Broker Fee
Auxiant Commission	Employee Group Services, Ltd dba Auxiant 424 First Ave NE Cedar Rapids IA 52401 TIN 42-1426202	9,970.79	Commission
Administrative Fee:		17,170.75	
Utilization Review:		2,295.95	
PPO Fees:		3,302.25	
Transplant Fees		3,599.15	
TOTAL PREMIUM PAID:			$ 198,812.09
Medical Claims		464,303.34	
Dental Claims		-	
Vision Claims		-	
STD Claims		-	
TOTAL CLAIMS PAID:			$ 464,303.34

Form 5500, if required, is due by the last day of the 7th month after the plan year ends. You should consult with your tax advisor regarding the plan's filing requirements and any other questions you have regarding Form 5500.

jmb072423

INSURANCE INFORMATION
This information is used on your Schedule A (Form 5500)

Name of Plan	MID IOWA FAMILY THERAPY CLINIC

Part I, Section 1

Delta Dental of Iowa
EIN: 42-0959302
NAIC CODE: 55786

Contract or ID Number: 41636
Approximate Number of Persons Covered @ End of Policy or Contract Year: 54
Policy or Contract Year 04/01/2022 - 03/31/2023

Part I, Section 2

Total Amount of Commissions Paid: $2,920.44
Total Fees Paid/Amount: $0.00

Name and Address of Recipient of Fees or Commissions

GROUP BENEFITS, LTD	Organization Code	3
12006 RIDGEMONT DRIVE	Amount of Commissions Paid:	$2,920.44
URBANDALE, IA 50323	Fees Paid/Amount	$0.00
	Fees Paid/Purpose	Sales and Persistency Bonus

Part III, Section 7

Benefit and Contract Type: Dental

Part III, Section 9

Non-experience rated contracts
(a) Total premiums or subscription charges paid to carrier $29,204.50

Delta Dental of Iowa hereby certifies that the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

New York Life Group Benefit Solutions
P.O. Box 20643
Lehigh Valley, PA 18002-0643

GROUP BENEFIT SOLUTIONS

Mid Iowa Family Therapy Clinic
600 1ST STREET
P.O. BOX 416
PERRY, IA 50220

Date Prepared: April 2, 2023

Anniversary
Annual Policy Information Report

Name of Insurance Carrier Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	SOK601256
Contract/Policy Year From:	04/01/2022
Contract/Policy Year To:	03/31/2023

Policy or Benefit Type
Basic AD&D

Approximate Number of persons covered at the end of the policy year:*

**Please refer to your census reports or billing statement for this information.*

Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.

Total premiums paid to Insurance Company during the policy year: $ 507.00

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
019164	PARADIGM BENEFITS PROGRAM 218 1ST STREET SW SUITE A Clarion IA 50525	$101.40	$ 0.00	Standard Commissions
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact a Revenue Management representative at 800.243.7445.

New York Life Group Benefit Solutions
P.O. Box 20643
Lehigh Valley, PA 18002-0643

GROUP BENEFIT SOLUTIONS

Mid Iowa Family Therapy Clinic
600 1ST STREET
P.O. BOX 416
PERRY, IA 50220

Date Prepared: April 2, 2023

Anniversary

Annual Policy Information Report

Name of Insurance Carrier Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	SGD602001
Contract/Policy Year From:	04/01/2022
Contract/Policy Year To:	03/31/2023

Policy or Benefit Type
Long Term Disability

Approximate Number of persons covered at the end of the policy year:*

**Please refer to your census reports or billing statement for this information.*

Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.

Total premiums paid to Insurance Company during the policy year: $ 7,578.30

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
019164	PARADIGM BENEFITS PROGRAM 218 1ST STREET SW SUITE A Clarion IA 50525	$1,515.63	$ 0.00	Standard Commissions
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	

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New York Life Group Benefit Solutions
P.O. Box 20643
Lehigh Valley, PA 18002-0643

GROUP BENEFIT SOLUTIONS

Mid Iowa Family Therapy Clinic
600 1ST STREET
P.O. BOX 416
PERRY, IA 50220

Date Prepared: April 2, 2023

Anniversary
Annual Policy Information Report

Name of Insurance Carrier	
Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	SGM602089
Contract/Policy Year From:	04/01/2022
Contract/Policy Year To:	03/31/2023

Policy or Benefit Type
Basic Term Life

Approximate Number of persons covered at the end of the policy year:*

**Please refer to your census reports or billing statement for this information.*

Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.

Total premiums paid to Insurance Company during the policy year: $ 2,230.80

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
019164	PARADIGM BENEFITS PROGRAM 218 1ST STREET SW SUITE A Clarion IA 50525	$446.16	$ 0.00	Standard Commissions
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	
		$ $	$ $	

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