

**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

**2023**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- A** This return/report is for:  a single-employer plan  a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans 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:  Form 5558  automatic extension  DFVC program  
 special extension (enter description)
- D** If the plan is a collectively-bargained plan, check here ..... ▶
- 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

<b>1a</b> Name of plan ORTHOPAEDIC & HAND SPECIALISTS, PA EMPLOYEES' 401(K) PROFIT SHARING PLAN AND TRUST	<b>1b</b> Three-digit plan number (PN) ▶ <u>001</u>													
	<b>1c</b> Effective date of plan <u>10/01/2002</u>													
<b>2a</b> 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) ORTHOPAEDIC & HAND SPECIALISTS PA  2718 HENRY STREET GREENSBORO, NC 27405	<b>2b</b> Employer Identification Number (EIN) <u>03-0471374</u>													
	<b>2c</b> Sponsor's telephone number <u>336-375-1007</u>													
	<b>2d</b> Business code (see instructions) <u>621111</u>													
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number													
<b>4</b> 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. <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN													
	<table border="1"> <tr> <td><b>5a</b></td> <td><u>5</u></td> </tr> <tr> <td><b>b</b></td> <td><u>0</u></td> </tr> <tr> <td><b>c(1)</b></td> <td><u>5</u></td> </tr> <tr> <td><b>c(2)</b></td> <td><u>0</u></td> </tr> <tr> <td><b>d(1)</b></td> <td><u>5</u></td> </tr> <tr> <td><b>d(2)</b></td> <td><u>0</u></td> </tr> <tr> <td><b>e</b></td> <td><u>0</u></td> </tr> </table>	<b>5a</b>	<u>5</u>	<b>b</b>	<u>0</u>	<b>c(1)</b>	<u>5</u>	<b>c(2)</b>	<u>0</u>	<b>d(1)</b>	<u>5</u>	<b>d(2)</b>	<u>0</u>	<b>e</b>
<b>5a</b>	<u>5</u>													
<b>b</b>	<u>0</u>													
<b>c(1)</b>	<u>5</u>													
<b>c(2)</b>	<u>0</u>													
<b>d(1)</b>	<u>5</u>													
<b>d(2)</b>	<u>0</u>													
<b>e</b>	<u>0</u>													

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**  
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, 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.	03/22/2024	DR GARY KUZMA
	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

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.).....  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.).....  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  Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_\_ (See instructions.)

<b>Part III Financial Information</b>			
<b>7</b> Plan Assets and Liabilities		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	334329	0
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	334329	0
<b>8</b> Income, Expenses, and Transfers for this Plan Year		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>		
<b>(2)</b> Participants.....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss).....	<b>8b</b>	24345	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	<b>8c</b>		24345
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	<b>8d</b>	355107	
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>	3567	
<b>g</b> Other expenses .....	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		358674
<b>i</b> Net income (loss) (subtract line 8h from line 8c).....	<b>8i</b>		-334329
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

<b>Part IV Plan Characteristics</b>	
<b>9a</b>	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2F 2G 2J 2K 2R 2T 3D
<b>b</b>	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

<b>Part V Compliance Questions</b>				
<b>10</b> During the plan year:		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<b>a</b> 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) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.).....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>		X	
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> 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.).....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> 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.....	<b>10i</b>			

**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

**a** If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a** 0

**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.)

<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

**Part VIII IRS Compliance Questions**

**14a** Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?  Yes  No

**14b** If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- Design-based safe harbor method
- "Prior year" ADP test
- "Current year" ADP test
- N/A

**15** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 06/30/2020 (MM/DD/YYYY) and the Opinion Letter serial number Q704115A.

**SUMMARY ANNUAL REPORT  
INSTRUCTIONS**

Attached is a copy of the Summary Annual Report for the Orthopaedic & Hand Specialists, PA Employees' 401(k) Profit Sharing Plan and Trust.

A copy of this report must be distributed to all plan participants. It is not filed with the Department of Labor when you submit your 5500 filing.

If you have any questions regarding this report please call us.

FBA401k  
704-521-6400

**SUMMARY ANNUAL REPORT FOR  
ORTHOPAEDIC & HAND SPECIALISTS, PA EMPLOYEES' 401(K) PROFIT SHARING PLAN AND TRUST**

This is a summary of the annual report for the Orthopaedic & Hand Specialists, PA Employees' 401(k) Profit Sharing Plan and Trust (Employer Identification Number 03-0471374, Plan Number 001) for the plan year 01/01/2023 through 12/31/2023. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

**Basic Financial Statement**

Plan expenses were \$358,674. These expenses included \$3,567 in administrative expenses and \$355,107 in benefits paid to participants and beneficiaries, \$0 in certain deemed and/or corrective distributions, and \$0 in other expenses. A total of 0 persons were participants in or beneficiaries of the plan at the end of the plan year.

The value of plan assets, after subtracting liabilities of the plan, was \$0 as of the end of the plan year, compared to \$334,329 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of -\$334,329. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$24,345, including employer contributions of \$0, employee contributions of \$0, other contributions/other income of \$0 and earnings from investments of \$24,345.

**Information Regarding Plan Assets**

The U.S. Department of Labor's regulations require that an independent qualified public accountant audit the plan's financial statements unless certain conditions are met for the audit requirement to be waived. This plan met the audit waiver conditions for the plan year beginning 01/01/2023 and therefore has not had an audit performed. Instead, the following information is provided to assist you in verifying that the assets reported on the Form 5500-SF were actually held by the plan.

At the end of the plan year, the plan had qualifying plan assets at the following institution(s):

Empower Retirement & Self Directed Brokerage Accounts at Fidelity Investments

The plan receives year-end statements from these regulated financial institutions that confirm the above information.

The remainder of the plan's assets were held in individual participant accounts with investments directed by participants and beneficiaries and with account statements from regulated financial institutions furnished to the participant or beneficiary at least annually and other qualifying assets.

Plan participants and beneficiaries have a right, on request and free of charge, to get copies of the financial institution year-end statements. If you want to examine or get copies of the financial institution year-end statements, please contact Dr Gary Kuzma, who is a representative of the plan administrator, at 2718 Henry Street, Greensboro, NC 27405 and phone number, 336-375-1007.

If you are unable to obtain or examine copies of the regulated financial institution statements, you may contact the regional office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for assistance by calling toll-free 866-444-EBSA (3272). A listing of EBSA regional offices can be found at <https://www.dol.gov/agencies/ebsa>.

General information regarding the audit waiver conditions applicable to the plan can be found on the U.S. Department of Labor Web site at <https://www.dol.gov/agencies/ebsa> under the heading "Frequently Asked Questions."

**Your Rights to Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. To obtain a copy of the full annual report, or any part thereof, write or call the office of Dr Gary Kuzma, who is a representative of the plan administrator, at 2718 Henry Street, Greensboro, NC 27405 and phone number, 336-375-1007.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan: 2718 Henry Street, Greensboro, NC 27405, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

#### **Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)