

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

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023

- A** This return/report is for:
 - a multiemployer plan
 - a single-employer plan
 - a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
 - a DFE (specify) _____
- B** This return/report is:
 - the first return/report
 - the final return/report
 - an amended return/report
 - a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ▶
- D** Check box if filing under:
 - Form 5558
 - automatic extension
 - special extension (enter description)
 - the DFVC program
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>KERNODLE CLINIC, INC. LONG TERM DISABILITY INCOME PLAN</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>KERNODLE CLINIC, INC.</u> <u>1234 HUFFMAN MILL ROAD</u> <u>BURLINGTON, NC 27215</u>	1c Effective date of plan <u>11/01/1982</u> 2b Employer Identification Number (EIN) <u>56-0520990</u> 2c Plan Sponsor's telephone number <u>336-538-1234</u> 2d Business code (see instructions) <u>621111</u>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	08/13/2024	MICHAEL LUNCEFORD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/13/2024	MICHAEL LUNCEFORD
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2022)
v. 220413

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 353
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). 6a(1) Total number of active participants at the beginning of the plan year 6a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits..... d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 353 6a(2) 368 6b 0 6c 0 6d 368 6e 6f 6g 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4H	
9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> 1 A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end.....	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions.....	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
7e(4)		
(5) Total deductions.....	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0

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

- 8** Benefit and contract type (check all applicable boxes)
- a** Health (other than dental or vision)
 - b** Dental
 - c** Vision
 - d** Life insurance
 - e** Temporary disability (accident and sickness)
 - f** Long-term disability
 - g** Supplemental unemployment
 - h** Prescription drug
 - i** Stop loss (large deductible)
 - j** HMO contract
 - k** PPO contract
 - l** Indemnity contract
 - m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e
10	Nonexperience-rated contracts:		
a	Total premiums or subscription charges paid to carrier	10a	94137
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210 - 0110 1210 - 0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2022</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023

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

<p>1a Name of plan KERNODLE CLINIC, INC. LONG TERM DISABILITY INCOME PLAN</p>	<p>1b Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>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) KERNODLE CLINIC, INC. 1234 HUFFMAN MILL ROAD BURLINGTON NC 27215</p>	<p>1c Effective date of plan 11/01/1982</p> <p>2b Employer Identification Number (EIN) 56-0520990</p> <p>2c Plan Sponsor's telephone number 336-538-1234</p> <p>2d Business code (see instructions) 621111</p>	

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	<u>Michael Lunceford</u> <small>Michael Lunceford (Aug 14, 2024 08:15 EDT)</small>	Aug 14, 2024	MICHAEL LUNCEFORD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<u>Michael Lunceford</u> <small>Michael Lunceford (Aug 14, 2024 08:15 EDT)</small>	Aug 14, 2024	MICHAEL LUNCEFORD
	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

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number																														
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4H

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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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 _____







LTD 5500 TO E-SIGN

Final Audit Report

2024-08-14

Created:	2024-08-14
By:	Clark Kernodle (clark@tcthlip.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAjYbNDJyI-VLu1OKvXhSF5u7SPiDTG-ry

"LTD 5500 TO E-SIGN" History

-  Document created by Clark Kernodle (clark@tcthlip.com)
2024-08-14 - 0:28:02 AM GMT- IP address: 66.57.144.210
-  Document emailed to traci.coleman@duke.edu for signature
2024-08-14 - 0:28:26 AM GMT
-  Email viewed by traci.coleman@duke.edu
2024-08-14 - 11:56:37 AM GMT- IP address: 136.226.69.27
-  Signer traci.coleman@duke.edu entered name at signing as Michael Lunceford
2024-08-14 - 12:15:17 PM GMT- IP address: 136.226.69.3
-  Document e-signed by Michael Lunceford (traci.coleman@duke.edu)
Signature Date: 2024-08-14 - 12:15:19 PM GMT - Time Source: server- IP address: 136.226.69.3
-  Agreement completed.
2024-08-14 - 12:15:19 PM GMT