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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for: [X] 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: [X] 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

1a Name of plan
CREATIVE CONSULTING SOLUTIONS INC 401K PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 10/01/2020

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)
CREATIVE CONSULTING SOLUTIONS IN

1599 KADLER AVE NE STE B
SAINT MICHAEL, MN 55376

2b Employer Identification Number (EIN) 41-1866054

2c Sponsor's telephone number 763-286-2649

2d Business code (see instructions) 541519

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

5a Total number of participants at the beginning of the plan year	**5a**	2
b Total number of participants at the end of the plan year	**5b**	2
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**5c(1)**	2
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**5c(2)**	2
d(1) Total number of active participants at the beginning of the plan year	**5d(1)**	2
d(2) Total number of active participants at the end of the plan year	**5d(2)**	2
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.	11/24/2025	LISA DALUGE
	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.) [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 [ ] 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	4732	15504
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	4732	15504
8 Income, Expenses, and Transfers for this Plan Year		**(a) Amount**	**(b) Total**
a Contributions received or receivable from: (1) Employers	8a(1)	4160	
(2) Participants	8a(2)	5900	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	900	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		10960
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	188	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		188
i Net income (loss) (subtract line 8h from line 8c)	8i		10772
j Transfers to (from) the plan (see instructions)	8j		

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:
2E 2F 2G 2J 2K 2S 2T 3D

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

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? Continue to answer "Yes" for any prior year failures until fully corrected. (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		1000
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	
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		3800
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? (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. ☐ Yes ☒ No

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**	
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)

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 10 / 06 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q704162A.

Creative Consulting Solutions, Inc.
Lisa Barthel-Daluge
Managing Director
1599 Kadler Ave NE, Suite B
St. Michael, MN 55376
Main: 763-497-9812
Direct: 763-286-2649

Creative Consulting Solutions, Inc.

Date: November 19, 2025
To: Department of Labor/IRS
From: Creative Consulting Solutions, Inc.
Federal ID Number 41-1866054 and Plan Number 287647
Lisa Barthel-Daluge

Subject: Form 5500 Late Filing and Request to Reduce or Waive Penalties

I am writing this letter as the administrator of our 401K program through ADP. I missed the extended date to file our form 5500. I was not able to get it filed by October 15th based on the request by ADP and the Notice CP216f. I am kindly requesting a reduction or a waiver to the penalties for the late filing for form 5500 for the following reasons:

- I was struggling during this time with my husband medically and was not in the office for several months. My husband went through back surgery. Four weeks later, he had to have quadruple heart by-pass surgery and a defibrillator put in. We have been working through follow-up appointments and rehab and I am finally back to work.
- Some screen shots of support for my husband's medical procedures/bills with dates – note these are just the two

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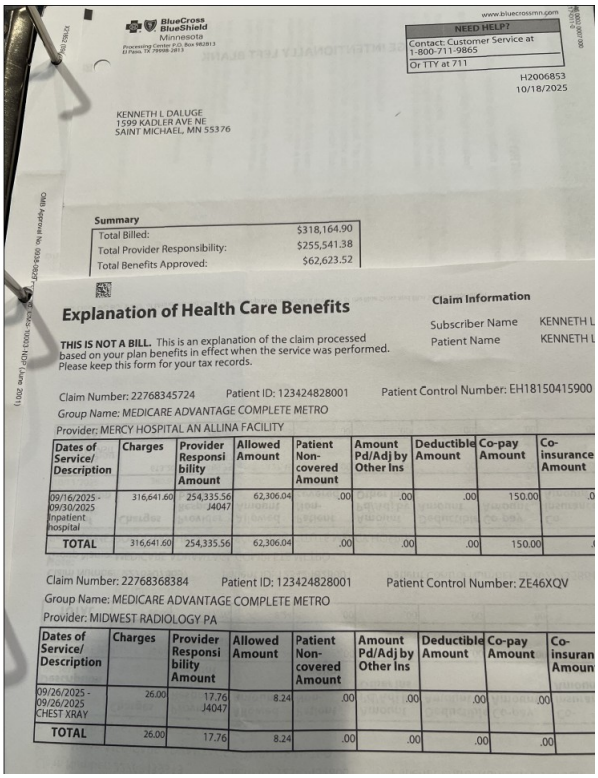
biggies.



BlueCross BlueShield Minnesota
Processing Center P.O. Box 982813 El Paso, TX 79998-2813

www.bluecrossmn.com

NEED HELP?
Contact: Customer Service at 1-800-711-9865
Or TTY at 711

H2006853
10/18/2025

KENNETH L DALUGE
1599 KADLER AVE NE
SAINT MICHAEL, MN 55376

Summary

Total Billed:	$318,164.90
Total Provider Responsibility:	$255,541.38
Total Benefits Approved:	$62,623.52

Explanation of Health Care Benefits

Claim Information
Subscriber Name KENNETH L
Patient Name KENNETH L

THIS IS NOT A BILL. This is an explanation of the claim processed based on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

Claim Number: 22768345724 Patient ID: 123424828001 Patient Control Number: EH18150415900
Group Name: MEDICARE ADVANTAGE COMPLETE METRO
Provider: MERCY HOSPITAL AN ALLINA FACILITY

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd/Adj by Other Ins	Deductible Amount	Co-pay Amount	Co-insurance Amount
09/16/2025 - 09/30/2025 Inpatient hospital	316,641.60	254,335.56 J4047	62,306.04	.00	.00	.00	150.00	.0
TOTAL	316,641.60	254,335.56	62,306.04	.00	.00	.00	150.00	

Claim Number: 22768368384 Patient ID: 123424828001 Patient Control Number: ZE46XQV
Group Name: MEDICARE ADVANTAGE COMPLETE METRO
Provider: MIDWEST RADIOLOGY PA

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd/Adj by Other Ins	Deductible Amount	Co-pay Amount	Co-insuran Amoun
09/26/2025 - 09/26/2025 CHEST XRAY	26.00	17.76 J4047	8.24	.00	.00	.00	.00	
TOTAL	26.00	17.76	8.24	.00	.00	.00	.00	

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-

Blue Cross and Blue Shield of Minnesota

Claim Number: 227691548 27 Patient ID: 123424828001 Patient Control Number: EP20777600580 Group Num

Group Name: MEDICARE ADVANTAGE COMPLETE METRO

Provider: ALLINA HEALTH HOSPITAL SERVICES

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd/Adj by Other Ins	Deductible Amount	Co-pay Amount	Co-insurance Amount	Paid Amount	Amount You
10/13/2025 - 10/17/2025 HOSPITAL DISCHARGE VISIT	380.90	300.88 J4047	80.02	.00	.00	.00	.00	.00	80.02	
TOTAL	380.90	300.88	80.02	.00	.00	.00	.00	.00	80.02	

Note:
J4047 This is the difference between the provider's charge and our allowance. Since the provider is in-network, you for this amount.

Patient Benefit Summary

Patient: KENNETH L DALUGE
Benefit Period: 01/01/2025 - 12/31/2025
$980.00 has been applied to your $5,100.00 individual out-of-pocket limit.
$980.00 has been applied to your $2,900.00 individual in network out-of-pocket limit.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from clai being processed and for which you have not been notified.

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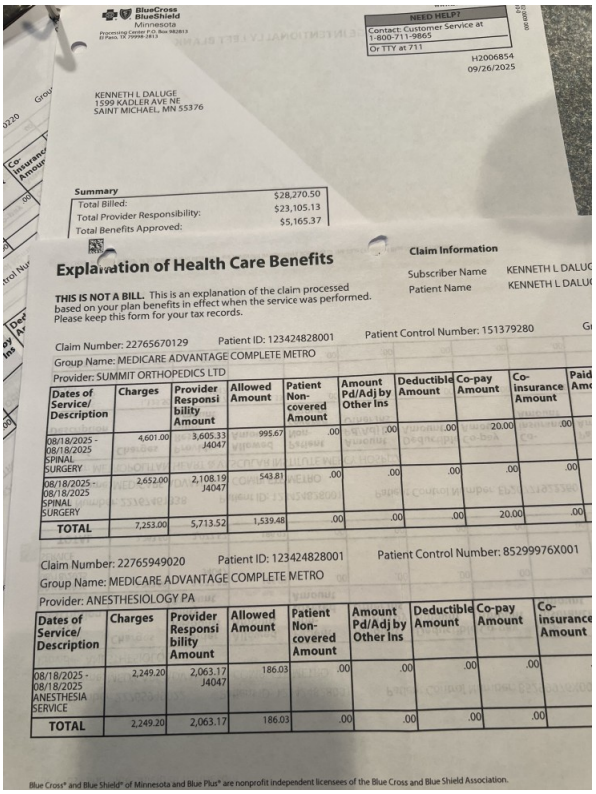

BlueCross BlueShield Minnesota

NEED HELP?
Contact Customer Service at 1-800-711-9865
Or TTY at 711

H2006854
09/26/2025

KENNETH L DALUGE
1599 KADLER AVE NE
SAINT MICHAEL, MN 55376

Summary

Total Billed:	$28,270.50
Total Provider Responsibility:	$23,105.13
Total Benefits Approved:	$5,165.37

Explanation of Health Care Benefits

Claim Information
Subscriber Name KENNETH L DALUG
Patient Name KENNETH L DALUG

THIS IS NOT A BILL. This is an explanation of the claim processed based on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

Claim Number: 22765670129 Patient ID: 123424828001 Patient Control Number: 151379280
Group Name: MEDICARE ADVANTAGE COMPLETE METRO
Provider: SUMMIT ORTHOPEDICS LTD

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd/Adj by Other Ins	Deductible Amount	Co-pay Amount	Co-insurance Amount	Paid Amt
08/18/2025 - 08/18/2025 SPINAL SURGERY	4,601.00	3,605.33 J4047	995.67	.00	.00	.00	20.00	.00	
08/18/2025 - 08/18/2025 SPINAL SURGERY	2,652.00	2,108.19 J4047	543.81	.00	.00	.00	.00	.00	
TOTAL	7,253.00	5,713.52	1,539.48	.00	.00	.00	20.00	.00	

Claim Number: 22765949020 Patient ID: 123424828001 Patient Control Number: 85299976X001
Group Name: MEDICARE ADVANTAGE COMPLETE METRO
Provider: ANESTHESIOLOGY PA

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd/Adj by Other Ins	Deductible Amount	Co-pay Amount	Co-insurance Amount
08/18/2025 - 08/18/2025 ANESTHESIA SERVICE	2,249.20	2,063.17 J4047	186.03	.00	.00	.00	.00	
TOTAL	2,249.20	2,063.17	186.03	.00	.00	.00	.00	

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

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- I have a small company with only one other employee at the time so do not have anyone else to cover this activity.
- I am working with ADP to get the form filed and this request processed. ADP indicated the fine for accepting being a delinquent filer is $750. With being out this much time, the $750 will bear additional financial burden.

I truly appreciate your consideration of reducing or waiving the delinquent filer fee for form 5500 for our company.

Thank You,
Lisa Barthel-Daluge

Lisa Barthel-Daluge

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