

**Form 5500-SF**Department of the Treasury  
Internal Revenue ServiceDepartment 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 10/01/2022 and ending 09/30/2023

- A** This return/report is for:  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:  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

<b>1a</b> Name of plan BLUE RIDGE NURSING CENTER EMPLOYEES' PENSION PLAN		<b>1b</b> Three-digit plan number (PN) ▶ 001
		<b>1c</b> Effective date of plan 10/01/1976
<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) BLUE RIDGE NURSING CENTER, INC.  P.O. BOX 459 STUART, VA 24171-0459		<b>2b</b> Employer Identification Number (EIN) 54-0794643
		<b>2c</b> Sponsor's telephone number 276-694-7161
		<b>2d</b> Business code (see instructions) 623000
<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
<b>5a</b> Total number of participants at the beginning of the plan year.....		<b>5a</b> 16
<b>b</b> Total number of participants at the end of the plan year .....		<b>5b</b> 15
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....		<b>5c</b>
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....		<b>5d(1)</b> 0
<b>d(2)</b> Total number of active participants at the end of the plan year.....		<b>5d(2)</b> 0
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		<b>5e</b> 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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	07/15/2024	RICK PULEO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2022)  
v.220413

- 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: 502877. (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>	164992	110148
<b>b</b> Total plan liabilities.....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a).....	<b>7c</b>	164992	110148
<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>	5405	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	<b>8c</b>		5405
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	<b>8d</b>	3303	
<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>	52840	
<b>g</b> Other expenses.....	<b>8g</b>	4106	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g).....	<b>8h</b>		60249
<b>i</b> Net income (loss) (subtract line 8h from line 8c).....	<b>8i</b>		-54844
<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: <u>1A</u>
<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? (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		1000000
<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>			
<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** 0

**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** 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)

<b>SCHEDULE SB (Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500 or 5500-SF.</b>	<small>OMB No. 1210-0110</small>  <b>2022</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 09/30/2023

▶ **Round off amounts to nearest dollar.**  
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>BLUE RIDGE NURSING CENTER EMPLOYEES' PENSION PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>001</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>BLUE RIDGE NURSING CENTER, INC.</u>		
<b>D</b> Employer Identification Number (EIN) <u>54-0794643</u>		

**E** Type of plan:  Single  Multiple-A  Multiple-B **F** Prior year plan size:  100 or fewer  101-500  More than 500

<b>Part I Basic Information</b>			
<b>1</b> Enter the valuation date: Month <u>10</u> Day <u>01</u> Year <u>2022</u>			
<b>2</b> Assets:			
a Market value.....	<b>2a</b>		<u>115141</u>
b Actuarial value.....	<b>2b</b>		<u>115141</u>
<b>3</b> Funding target/participant count breakdown			
	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment .....	<u>0</u>	<u>0</u>	<u>0</u>
b For terminated vested participants.....	<u>16</u>	<u>66692</u>	<u>66692</u>
c For active participants.....	<u>0</u>	<u>0</u>	<u>0</u>
d Total .....	<u>16</u>	<u>66692</u>	<u>66692</u>
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions.....	<b>4a</b>		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	<b>4b</b>		
<b>5</b> Effective interest rate.....	<b>5</b>		<u>5.58 %</u>
<b>6</b> Target normal cost .....			
a Present value of current plan year accruals.....	<b>6a</b>		<u>0</u>
b Expected plan-related expenses .....	<b>6b</b>		<u>40000</u>
c Total (line 6a + line 6b) .....	<b>6c</b>		<u>40000</u>

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>		
	Signature of actuary	<u>07/12/2024</u> Date
	<u>JEFFREY R. SMITH, FSA, EA</u> Type or print name of actuary	<u>23-05839</u> Most recent enrollment number
	<u>STANLEY BENEFIT SERVICES, INC.</u> Firm name	<u>336-271-4450</u> Telephone number (including area code)
	<u>7800 MCCLLOUD ROAD SUITE 200 GREENSBORO, NC 27409</u> Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

<b>Part II Beginning of Year Carryover and Prefunding Balances</b>		(a) Carryover balance	(b) Prefunding balance
<b>7</b>	Balance at beginning of prior year after applicable adjustments (line 13 from prior year).....	0	663869
<b>8</b>	Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....		0
<b>9</b>	Amount remaining (line 7 minus line 8) .....	0	663869
<b>10</b>	Interest on line 9 using prior year's actual return of <u>-7.32</u> % .....	0	-48595
<b>11</b>	Prior year's excess contributions to be added to prefunding balance:		
	<b>a</b> Present value of excess contributions (line 38a from prior year).....		34229
	<b>b(1)</b> Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.43</u> %.....		1859
	<b>b(2)</b> Interest on line 38b from prior year Schedule SB, using prior year's actual return .....		
	<b>c</b> Total available at beginning of current plan year to add to prefunding balance.....		36088
	<b>d</b> Portion of (c) to be added to prefunding balance.....		
<b>12</b>	Other reductions in balances due to elections or deemed elections.....	0	566825
<b>13</b>	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12).....	0	48449

<b>Part III Funding Percentages</b>			
<b>14</b>	Funding target attainment percentage.....	<b>14</b>	100.00 %
<b>15</b>	Adjusted funding target attainment percentage .....	<b>15</b>	100.00 %
<b>16</b>	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	<b>16</b>	100.00 %
<b>17</b>	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage. ....	<b>17</b>	%

<b>Part IV Contributions and Liquidity Shortfalls</b>		<b>18 Contributions made to the plan for the plan year by employer(s) and employees:</b>					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
<b>Totals ▶</b>			<b>18(b)</b>	0	<b>18(c)</b>	0	

**19** Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

<b>a</b> Contributions allocated toward unpaid minimum required contributions from prior years.....	<b>19a</b>	0
<b>b</b> Contributions made to avoid restrictions adjusted to valuation date. ....	<b>19b</b>	0
<b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date. ....	<b>19c</b>	0

**20** Quarterly contributions and liquidity shortfalls:

**a** Did the plan have a "funding shortfall" for the prior year? .....  Yes  No

**b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? .....  Yes  No

**c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

**21** Discount rate:

<b>a</b> Segment rates:	1st segment: 4.75 %	2nd segment: 5.18 %	3rd segment: 5.92 %	<input type="checkbox"/> N/A, full yield curve used
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**b** Applicable month (enter code)..... **21b** 0

**22** Weighted average retirement age ..... **22** 65

**23** Mortality table(s) (see instructions)  Prescribed - combined  Prescribed - separate  Substitute

**Part VI Miscellaneous Items**

**24** Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....  Yes  No

**25** Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....  Yes  No

**26** Demographic and benefit information

**a** Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....  Yes  No

**b** Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ...  Yes  No

**27** If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment ..... **27**

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years.....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29).....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

**31** Target normal cost and excess assets (see instructions):

<b>a</b> Target normal cost (line 6c).....	<b>31a</b>	40000
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	0

<b>32</b> Amortization installments:	Outstanding Balance	Installment
<b>a</b> Net shortfall amortization installment .....	0	0
<b>b</b> Waiver amortization installment.....	0	0

**33** If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_) and the waived amount ..... **33**

<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)....	<b>34</b>	40000
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	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement.....	0	40000	40000

**36** Additional cash requirement (line 34 minus line 35)..... **36** 0

**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)..... **37** 0

**38** Present value of excess contributions for current year (see instructions)

<b>a</b> Total (excess, if any, of line 37 over line 36)	<b>38a</b>	0
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0

**39** Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)..... **39** 0

**40** Unpaid minimum required contributions for all years..... **40** 0

**Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)**

**41** If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies.  2019  2020  2021

## Funding – Assumptions

### Interest Rates

		2021		2022	
		Minimum	Others	Minimum	Others
Funding Segment Rates:	1 <sup>st</sup> Segment	4.75%	1.01%	4.75%	1.57%
	2 <sup>nd</sup> Segment	5.36%	2.65%	5.18%	3.21%
	3 <sup>rd</sup> Segment	6.11%	3.34%	5.92%	3.66%
	Effective Rate	5.43%	2.70%	5.58%	3.47%

### Disability

None assumed.

### Mortality

2022 IRS Mortality Table (previously, the IRS 2021 Mortality Table).

### Termination

Graduated Rates (see sample rates below)

Age	Probability of Termination
25	9.67%
40	7.75%
55	1.55%

### Assumed Retirement

The Assumed Retirement date is the attainment of age 65 and the 5-year anniversary of Plan Participation.

### Marriage

Male spouses are assumed to be 3 years older than their wives.

It is assumed that 90 percent of male and female participants are married.

### Salary Scale

N/A.

### Expenses

Expenses assumed to be paid from the trust are added to the Target Normal Cost.

Blue Ridge Nursing Center, Inc.  
PO Box 459  
Stuart, VA 24171-1459

AUTHORIZATION OF PRACTITIONER TO ELECTRONICALLY SIGN AND FILE

Name of Plan: Blue Ridge Nursing Center Employees' Pension Plan  
EIN: 54-0794643  
Plan year ending: September 30, 2023

I hereby authorize American Trust to electronically sign and file the above-named return/report through EFAST2. If required, the annual Form 8955-SSA will also be filed electronically.

I understand that in granting this authority:

1. I must manually sign and date page 1 of Form 5500 and provide a scanned copy of that signature page to American Trust before the electronic filing can be initiated.
2. American Trust will retain a copy of this written authorization in its records.
3. American Trust will notify the individual signing below as plan administrator about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this annual return/report.
4. A copy of my signature, as it appears on page 1 of Form 5500, will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
5. American Trust shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.

This authorization is applicable only to the filing for the above-named Plan and applies only for Plan Year end stated above.

Plan Administrator: \_\_\_\_\_

Rick Puleo

Date: \_\_\_\_\_

7/15/2024

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American Trust certifies that the firm will use the authority granted only for the express purposes described above, that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST filing and that the firm will take reasonable steps to assure that confidential information provided by the Plan Administrator is protected from unauthorized disclosure.

Blue Ridge Nursing Center, Inc.  
PO Box 459  
Stuart, VA 24171-1459

**AUTHORIZATION OF PRACTITIONER TO ELECTRONICALLY SIGN AND FILE**

Name of Plan: Blue Ridge Nursing Center Employees' Pension Plan  
EIN: 54-0794643  
Plan year ending: September 30, 2023

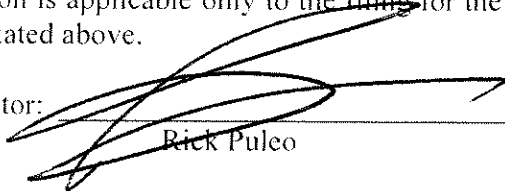
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2. American Trust will retain a copy of this written authorization in its records.
3. American Trust will notify the individual signing below as plan administrator about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this annual return/report.
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Plan Administrator: \_\_\_\_\_



Rick Puleo

Date: \_\_\_\_\_

7/15/2024

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**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 10/01/2022 and ending 09/30/2023

- A** This return/report is for:  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:  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**

<b>1a</b> Name of plan BLUE RIDGE NURSING CENTER EMPLOYEES' PENSION PLAN		<b>1b</b> Three-digit plan number (PN) ▶	001
		<b>1c</b> Effective date of plan	10/01/1976
<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) BLUE RIDGE NURSING CENTER, INC.  P.O. BOX 459  STUART VA 24171-0459		<b>2b</b> Employer Identification Number (EIN)	54-0794643
		<b>2c</b> Sponsor's telephone number	276-694-7161
		<b>2d</b> Business code (see instructions)	623000
<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	
<b>5a</b> Total number of participants at the beginning of the plan year		<b>5a</b>	16
<b>b</b> Total number of participants at the end of the plan year		<b>5b</b>	15
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		<b>5c</b>	
<b>d(1)</b> Total number of active participants at the beginning of the plan year		<b>5d(1)</b>	0
<b>d(2)</b> Total number of active participants at the end of the plan year		<b>5d(2)</b>	0
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		<b>5e</b>	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		Date	7/15/2024	Enter name of individual signing as plan administrator	BRUCE PULEO
	Signature of employer/plan sponsor	Date	7/15/2024	Enter name of individual signing as employer or plan sponsor	

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

Form 5500-SF (2022)  
v.220413

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500 or 5500-SF.</b>	<small>OMB No. 1210-0110</small>  <b>2022</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 09/30/2023

▶ **Round off amounts to nearest dollar.**  
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan BLUE RIDGE NURSING CENTER EMPLOYEES' PENSION PLAN	<b>B</b> Three-digit plan number (PN) ▶	001
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF BLUE RIDGE NURSING CENTER, INC.	<b>D</b> Employer Identification Number (EIN) 54-0794643	
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

**Part I Basic Information**

<b>1</b> Enter the valuation date:	Month <u>10</u> Day <u>01</u> Year <u>2022</u>		
<b>2</b> Assets:			
<b>a</b> Market value .....	<b>2a</b>	115,141	
<b>b</b> Actuarial value .....	<b>2b</b>	115,141	
<b>3</b> Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
<b>a</b> For retired participants and beneficiaries receiving payment .....	0	0	0
<b>b</b> For terminated vested participants .....	16	66,692	66,692
<b>c</b> For active participants .....	0	0	0
<b>d</b> Total .....	16	66,692	66,692
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
<b>a</b> Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		
<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....	<b>4b</b>		
<b>5</b> Effective interest rate .....	<b>5</b>		5.58%
<b>6</b> Target normal cost .....			
<b>a</b> Present value of current plan year accruals .....	<b>6a</b>		0
<b>b</b> Expected plan-related expenses .....	<b>6b</b>		40,000
<b>c</b> Total (line 6a + line 6b) .....	<b>6c</b>		40,000

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	 Signature of actuary JEFFREY R. SMITH, FSA, EA Type or print name of actuary STANLEY BENEFIT SERVICES, INC. Firm name 7800 MCCLOUD ROAD SUITE 200 GREENSBORO NC 27409 Address of the firm	<u>07/12/2024</u> Date <u>2305839</u> Most recent enrollment number <u>336-271-4450</u> Telephone number (including area code)
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## Principal Plan Provisions

### General Information

Valuation Date	October 1, 2022
Original Effective Date	October 1, 1976
Effective Date of Last Restatement	October 1, 2013
Plan Year	October 1 to September 30
Employer Fiscal Year	January 1 to December 31

### Eligibility Requirements

Each employee becomes a Participant on the Plan Entry Date on or next following the attainment of age 21 years and completion of a Qualifying Year of Service.

Employees of The Landmark Group, LLC are ineligible to participate except for those Employees of The Landmark Group who are in an "Administration" status position.

### Plan Entry Dates

An eligible employee will participate in the Plan on the October 1 or April 1 on or next following completion of the eligibility requirements.

### Credited Service

#### *Definition*

Prior to October 1, 1976, all full years and completed months of continuous employment.  
After October 1, 1976, all Plan Years with 1,000 or more Hours of Service.

### Compensation

Compensation is the total compensation received by the Participant for the prior calendar year, including bonuses, overtime and commissions and any amounts deferred under a qualified 401(k), 403(b) or 125 Plan. Excluded are amounts for other fringe benefits, moving expenses, automobile allowances, taxable values of employer paid group term life insurance, and any other special forms of payment.

For service prior to October 1, 1997, Annual Compensation is the high 3 consecutive plan years average for the 10 years preceding October 1, 1997, and afterwards, the total Annual Compensation for each plan year.

### Vesting

All Participants shall be vested according to the following schedule:

Years of Service	% Vested
Less than 5	0%
5 or more	100%

All participants shall be 100% vested upon attainment of their Normal Retirement Age.

All participants shall be 100% vested upon attainment of their Disability Retirement Date.

The vested benefit shall be the vested portion of the Accrued Benefit as of the date of determination.

## **Normal Retirement**

### ***Eligibility***

The Normal Retirement Date for each Participant is the first of the month on or next following the later of the attainment of age 65, or the fifth year anniversary of Plan participation.

### ***Benefit***

The amount of annual retirement benefit payable according to the Normal Annuity Form of payment is calculated as follows:

- 0.75% of Annual Compensation for each Year of Benefit, plus
- 0.65% of Annual Compensation in excess of Covered Compensation for each Year of Benefit Service (maximum 35 years).

Covered compensation is the average of Social Security Taxable Wage Base for the 35-year period ending at the Participant's Social Security Retirement Age, in effect at the beginning of each plan year.

### ***Minimum Benefits***

The minimum Normal Retirement Benefit is \$30 per month.

***Benefit accrual was frozen as of September 30, 2019.***

## **Accrued Benefit**

The Monthly Accrued Benefit, with respect to the formula above, as of any date, is calculated using Years of Benefit Service and Compensation applicable to each Year of Benefit Service as of the date of determination.

## **Delayed Retirement**

Eligibility is the first of the month on or next following the actual date the Participant terminates employment after Normal Retirement Date. The Benefit is based on Years of Benefit Service and Annual Compensation as of the actual retirement date or actuarial equivalent of Normal Retirement Benefit, if greater.

## **Early Retirement**

### ***Eligibility***

Eligibility is contingent upon the attainment of age 55 and the completion of 15 years of Vesting Service.

### ***Benefit***

A Participant may retire on the first day of any month following attainment of eligibility. The amount of the monthly Early Retirement Benefit is the Participant's Accrued Benefit reduced to reflect the early commencement of payments.

The reduction is 1/180 for each of the first 60 months and 1/360 for each of the next 60 months by which the benefit commences prior to Normal Retirement Date.

**Disability Retirement*****Eligibility***

Totally and permanently disabled before Normal Retirement Date and not yet eligible for Early Retirement.

***Benefit***

Accrued Benefit as of the Disability Retirement Date.

***Payments***

Normal Retirement Date or prior to Normal Retirement Date with reduced benefits after 6 month waiting period.

**Death Benefit*****Eligibility***

Eligibility is contingent upon the vesting date and a minimum of 1 year of marriage.

***Benefit***

**Benefit:** A benefit computed assuming the Participant had terminated on date of death and had elected a 50% Survivor Annuity.

**Type of Payment:** Monthly benefit or lump sum if Actuarially Equivalent present value of the survivor's benefit is \$5,000 or less.

**Date of Payment:** At what would have been the participant's Earliest Retirement Date.

**Methods of Payments**

Under the Normal Form of payment, a Participant's retirement annuity is payable monthly for life, without further payments after death. A Participant may elect to receive the annuity under one of the following actuarially-equivalent optional modes:

- A reduced benefit is paid to the Participant while the participant and the designated contingent annuitant are both living, with such benefit (50%, 75% or 100% of such benefit thereof) continued after the death of either party, payable for the subsequent lifetime of the survivor.
- A reduced benefit is paid to the Participant for life, with 120, 180 or 240 monthly payments guaranteed. If the Participant dies within the guarantee period, the payments continue to a beneficiary until 120, 180 or 240 have been paid.
- A lump sum payment of the actuarial equivalent of the participant's retirement benefit.

**Contributions**

The entire cost of the plan is paid by the Employer, with no employee contributions.

**Amendments**

The Employer has reserved the right to amend this Plan at any time.

The Pension Benefit Guaranty Corporation reserves the right to terminate the Plan if the Employer fails to meet the minimum funding standards, or is unable to pay benefits when due. If the Plan is terminated, the plan assets will be distributed among the plan participants, and the Employer shall be liable for any unfunded vested benefits to the extent required by law.