

**Form 5500-SF**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Short Form Annual Return/Report of Small Employee Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110  
1210-0089

**2022**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

- A** This return/report is for:  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 <u>DEER VALLEY HOME HEALTH SERVICES INC PENSION PLAN &amp; TRUST</u>		<b>1b</b> Three-digit plan number (PN) ▶ <u>003</u>
		<b>1c</b> Effective date of plan <u>01/01/2013</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) <u>DEER VALLEY HOME HEALTH SERVICES INC</u>  <u>8600 AIRPORT ROAD SUITE 104</u> <u>ST LOUIS, MO 63134</u>		<b>2b</b> Employer Identification Number (EIN) <u>20-1611498</u>
		<b>2c</b> Sponsor's telephone number <u>314-355-3679</u>
		<b>2d</b> Business code (see instructions) <u>621610</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
<b>5a</b> Total number of participants at the beginning of the plan year.....		<b>5a</b> <u>48</u>
<b>b</b> Total number of participants at the end of the plan year .....		<b>5b</b> <u>28</u>
<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> <u>48</u>
<b>d(2)</b> Total number of active participants at the end of the plan year.....		<b>5d(2)</b> <u>28</u>
<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> <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.

<b>SIGN HERE</b>	<u>Filed with authorized/valid electronic signature.</u>	<u>10/09/2024</u>	<u>ADA TAYLOR, TTEE</u>
	<b>Signature of plan administrator</b>	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	<u>Filed with authorized/valid electronic signature.</u>	<u>10/09/2024</u>	<u>ADA TAYLOR, TTEE</u>
	<b>Signature of employer/plan sponsor</b>	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: 560015. (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>	1213414	569966
<b>b</b> Total plan liabilities.....	<b>7b</b>	0	0
<b>c</b> Net plan assets (subtract line 7b from line 7a).....	<b>7c</b>	1213414	569966
<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>	0	
<b>(2)</b> Participants.....	<b>8a(2)</b>	0	
<b>(3)</b> Others (including rollovers).....	<b>8a(3)</b>	0	
<b>b</b> Other income (loss).....	<b>8b</b>	-34198	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	<b>8c</b>		-34198
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	<b>8d</b>	609250	
<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>		
<b>g</b> Other expenses.....	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g).....	<b>8h</b>		609250
<b>i</b> Net income (loss) (subtract line 8h from line 8c).....	<b>8i</b>		-643448
<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 3D</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		500000
<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**

**b PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- Yes.
- No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- No. Other. Provide explanation \_\_\_\_\_

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

**a** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. ....Month Day Year

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

**b** Enter the minimum required contribution for this plan year ..... **12b**

**c** Enter the amount contributed by the employer to the plan for this plan year ..... **12c**

**d** Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) ..... **12d**

**e** Will the minimum funding amount reported on line 12d be met by the funding deadline?.....  Yes  No  N/A

**Part VII Plan Terminations and Transfers of Assets**

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

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

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

**c** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

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

Form **5558**  
(Rev. September 2018)

### Application for Extension of Time To File Certain Employee Plan Returns

OMB No. 1545-0212

Department of the Treasury  
Internal Revenue Service

► For Privacy Act and Paperwork Reduction Act Notice, see Instructions.  
► Go to [www.irs.gov/Form5558](http://www.irs.gov/Form5558) for the latest information.

File With IRS Only

#### Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions) <b>DEER VALLEY HOME HEALTH SERVICES</b>	B Filer's identifying number (see instructions)			
	Employer identification number (EIN) (9 digits XX-XXXXXXX) <b>20-1611498</b>			
	Social security number (SSN) (9 digits XXX-XX-XXXX)			
Number, street, and room or suite no. (if a P.O. box, see instructions) <b>8600 AIRPORT ROADS SUITE 104</b>				
City or town, state, and ZIP code <b>ST LOUIS, MO 63134</b>				
C Plan name	Plan number	Plan year ending—		
<b>DEER VALLEY HOME HEALTH SERVICES PENSION PLAN AND TRUST EIN: 46-4386912</b>	<b>003</b>	MM	DD	YYYY
		<b>12</b>	<b>31</b>	<b>2022</b>

#### Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

- 1  Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, C above.
- 2 I request an extension of time until 10/15/2023 to file Form 5500 series. See instructions.  
Note: A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until 1/1 to file Form 8955-SSA. See instructions.  
Note: A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is automatically approved to the date shown on line 2 and/or line 3 (above) if (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and (b) the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.

#### Part III Extension of Time To File Form 5330 (see instructions)

- 4 I request an extension of time until 1/1 to file Form 5330.  
You may be approved for up to a 6-month extension to file Form 5330, after the normal due date of Form 5330.
- a Enter the Code section(s) imposing the tax . . . . . ► 

a
---
- b Enter the payment amount attached . . . . . ► 

b
---
- c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . . . ► 

c
---

5 State in detail why you need the extension:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ► \_\_\_\_\_ Date ► \_\_\_\_\_

**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 section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110  
1210-0089

**2022**

This Form is Open to  
Public Inspection

**Part I Annual Report Identification Information**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

- A** This return/report is for:  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 Deer Valley Home Health Services Inc		<b>1b</b> Three-digit plan number (PN) ▶ 003
<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) Deer Valley Home Health Services Inc  8600 Airport Road Suite 104  US St Louis MO 63134		<b>1c</b> Effective date of plan 01/01/2013
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor		<b>2b</b> Employer Identification Number (EIN) 20-1611498
<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>2c</b> Sponsor's telephone number (314) 355-3679
<b>5a</b> Total number of participants at the beginning of the plan year		<b>2d</b> Business code (see instructions) 621610
<b>b</b> Total number of participants at the end of the plan year		<b>3b</b> Administrator's EIN
<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>3c</b> Administrator's telephone number
<b>d(1)</b> Total number of active participants at the beginning of the plan year		<b>4b</b> EIN
<b>d(2)</b> Total number of active participants at the end of the plan year		<b>4d</b> PN
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		<b>5a</b> 48
		<b>5b</b> 28
		<b>5c</b>
		<b>5d(1)</b> 48
		<b>5d(2)</b> 28
		<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>	<i>Ada Taylor, Trustee</i>		Ada Taylor, TTEE
	Signature of plan administrator	Date <u>10-9-2022</u>	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	<i>Ada Taylor, Trustee</i>		Ada Taylor, Pres
	Signature of employer/plan sponsor	Date <u>10-9-2022</u>	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 year 560015 (See instructions.)

**Part III Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets	7a	1,213,414	569,966
<b>b</b> Total plan liabilities	7b	0	0
<b>c</b> Net plan assets (subtract line 7b from line 7a)	7c	1,213,414	569,966
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers	8a(1)	0	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
<b>b</b> Other income (loss)	8b	(34,198)	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		(34,198)
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	609,250	
<b>e</b> Certain deemed and/or corrective distributions (see instructions)	8e		
<b>f</b> Administrative service providers (salaries, fees, commissions)	8f		
<b>g</b> Other expenses	8g		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		609,250
<b>i</b> Net income (loss) (subtract line 8h from line 8c)	8i		(643,448)
<b>j</b> 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:  
 1A 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
<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)	10a		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
<b>c</b> Was the plan covered by a fidelity bond?	10c	X		500,000
<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?	10d		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.)	10e		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan?	10f		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h			
<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	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>b</b> Enter the minimum required contribution for this plan year.....	<b>12b</b>	
<b>c</b> Enter the amount contributed by the employer to the plan for the plan year .....	<b>12c</b>	
<b>d</b> 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) .....	<b>12d</b>	
<b>e</b> Will the minimum funding amount reported on line 12d be met by the funding deadline? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

**Part VII Plan Terminations and Transfers of Assets**

**13a** Has a resolution to terminate the plan been adopted in any plan year?  Yes  No  
 If "Yes," enter the amount of any plan assets that reverted to the employer this year **13a**

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

**c** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

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

<b>SCHEDULE A (Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Insurance Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>  <b>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</b>	OMB No. 1210-0110  <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 **01/01/2022** and ending **12/31/2022**

<b>A</b> Name of plan Deer Valley Home Health Services Inc	<b>B</b> Three-digit plan number (PN) ►	003
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<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 Deer Valley Home Health Services Inc	<b>D</b> Employer Identification Number (EIN) 20-1611498
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**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
American United Life Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0145825	60895	various	28	01/01/2022	12/31/2022

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a)</b> Total amount of commissions paid 0	<b>(b)</b> Total amount of fees paid 0
--	---

**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(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

(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

(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

(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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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

(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	

**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.

<b>4</b> Current value of plan's interest under this contract in the general account at year end . . . . .	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end . . . . .	<b>5</b>	569,960

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶  
 unisex life insurance & fixed indexed annuities

<b>b</b> Premiums paid to carrier . . . . .	<b>6b</b>	0
<b>c</b> Premiums due but unpaid at the end of the year . . . . .	<b>6c</b>	0
<b>d</b> 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 ▶ n/a	<b>6d</b>	0

**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 on contract (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year . . . . .	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year . . . . .	<b>7c(1)</b>	
(2) Dividends and credits . . . . .	<b>7c(2)</b>	
(3) Interest credited during the year . . . . .	<b>7c(3)</b>	
(4) Transferred from separate account . . . . .	<b>7c(4)</b>	
(5) Other (specify below) . . . . . ▶	<b>7c(5)</b>	
(6) Total additions . . . . .	<b>7c(6)</b>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	<b>7d</b>	
<b>e</b> Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year . . . . .	<b>7e(1)</b>	
(2) Administration charge made by carrier . . . . .	<b>7e(2)</b>	
(3) Transferred to separate account . . . . .	<b>7e(3)</b>	
(4) Other (specify below) . . . . . ▶	<b>7e(4)</b>	
(5) Total deductions . . . . .	<b>7e(5)</b>	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) . . . . .	<b>7f</b>	

**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 organization(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:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier	<b>10a</b>	
<b>b</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	<b>10b</b>	

**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. ▶

## Application for Extension of Time To File Certain Employee Plan Returns

Department of the Treasury  
Internal Revenue Service

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.  
▶ Go to [www.irs.gov/form5558](http://www.irs.gov/form5558) for the latest information.

**File With IRS Only**

**Part I Identification**

<p><b>A</b> Name of filer, plan administrator, or plan sponsor (see instructions) <b>Deer Valley Home Health Services Inc</b></p> <p>Number, street, and room or suite no. (If a P.O. box, see instructions) <b>8600 Airport Road Suite 104</b></p> <p>City or town, state, and ZIP code <b>St Louis MO 63134</b></p>	<p><b>B</b> Filer's identifying number (see instructions)</p> <p>Employer identification number (EIN)(9 digits XX-XXXXXXX) <b>20-1611498</b></p> <p>Social security number (SSN) (9 digits XXX-XX-XXXX)</p>													
<p><b>C</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 50%;">Plan name</th> <th rowspan="2" style="width: 10%;">Plan number</th> <th colspan="3" style="width: 40%;">Plan year ending--</th> </tr> <tr> <th style="width: 10%;">MM</th> <th style="width: 10%;">DD</th> <th style="width: 20%;">YYYY</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><b>Deer Valley Home Health Services Inc Pension Plan &amp; Trust</b></td> <td style="text-align: center;"><b>003</b></td> <td style="text-align: center;"><b>12</b></td> <td style="text-align: center;"><b>31</b></td> <td style="text-align: center;"><b>2022</b></td> </tr> </tbody> </table>	Plan name	Plan number	Plan year ending--			MM	DD	YYYY	<b>Deer Valley Home Health Services Inc Pension Plan &amp; Trust</b>	<b>003</b>	<b>12</b>	<b>31</b>	<b>2022</b>	
Plan name			Plan number	Plan year ending--										
	MM	DD		YYYY										
<b>Deer Valley Home Health Services Inc Pension Plan &amp; Trust</b>	<b>003</b>	<b>12</b>	<b>31</b>	<b>2022</b>										

**Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA**

- 1  Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, C above.
- 2 I request an extension of time until 10 / 16 / 2023 to file Form 5500 series (see instructions).  
**Note.** A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until 10 / 16 / 2023 to file Form 8955-SSA (see instructions).  
**Note.** A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

**Part III Extension of Time To File Form 5330 (see instructions)**

- 4 I request an extension of time until      /      /      to file Form 5330.  
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.
- a Enter the Code section(s) imposing the tax . . . . . ▶ 

a
---
- b Enter the payment amount attached . . . . . ▶ 

b
---
- c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . . . ▶ 

c
---
- 5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ Ada Inglar Date ▶ 10-9-2024