

|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <div>Form 5500</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security<br/>Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Annual Return/Report of Employee Benefit Plan</div> <div>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div> | <div>OMB Nos. 1210-0110<br/>1210-0089</div> <div>2023</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I                                                                                     | Annual Report Identification Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| A                                                                                          | This return/report is for: <div><div><input type="checkbox"/> a multiemployer plan</div><div><input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)</div><div><input checked="" type="checkbox"/> a single-employer plan</div><div><input type="checkbox"/> a DFE (specify) _____</div><div><input type="checkbox"/> the first return/report</div><div><input type="checkbox"/> the final return/report</div><div><input type="checkbox"/> an amended return/report</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months)</div></div> |
| C                                                                                          | If the plan is a collectively-bargained plan, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| D                                                                                          | Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558</div><div><input type="checkbox"/> automatic extension</div><div><input type="checkbox"/> the DFVC program</div><div><input type="checkbox"/> special extension (enter description)</div></div>                                                                                                                                                                                                                                                                                                                                                                                                       |
| E                                                                                          | If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. .... ▶ <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|         |                                                                                                                                                                                                                                                                                                                                                                       |
|---------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information—enter all requested information                                                                                                                                                                                                                                                                                                                |
| 1a      | Name of plan<br>COMPLETE CARE COMMUNITY HEALTH CENTER, INC. RETIREMENT PLAN                                                                                                                                                                                                                                                                                           |
| 1b      | Three-digit plan number (PN) ▶ 001                                                                                                                                                                                                                                                                                                                                    |
| 1c      | Effective date of plan<br>01/01/2017                                                                                                                                                                                                                                                                                                                                  |
| 2a      | Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>COMPLETE CARE COMMUNITY HEALTH CENTER, INC.<br><br>3000 S. ROBERTSON BLVD., STE. #280<br>LOS ANGELES, CA 90034 |
| 2b      | Employer Identification Number (EIN)<br>73-1663091                                                                                                                                                                                                                                                                                                                    |
| 2c      | Plan Sponsor's telephone number<br>310-730-6362                                                                                                                                                                                                                                                                                                                       |
| 2d      | Business code (see instructions)<br>621111                                                                                                                                                                                                                                                                                                                            |

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

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

|           |                                                   |            |                                                              |
|-----------|---------------------------------------------------|------------|--------------------------------------------------------------|
| SIGN HERE | Filed with authorized/valid electronic signature. | 09/30/2024 | YURY AKOPYAN                                                 |
|           | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| SIGN HERE | Filed with authorized/valid electronic signature. | 09/30/2024 | YURY AKOPYAN                                                 |
|           | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE |                                                   |            |                                                              |
|           | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>3b</b> Administrator's EIN<br><br><b>3c</b> Administrator's telephone number<br><br><div style="background-color: #cccccc; height: 40px; width: 100%;"></div>                                                                                                                                                                 |
| <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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                                                                                                                                                                                |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>5</b> 157                                                                                                                                                                                                                                                                                                                     |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits .....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... | <div style="background-color: #cccccc; height: 20px; width: 100%;"></div> <div style="background-color: #cccccc; height: 20px; width: 100%;"></div> <b>6a(1)</b> 120<br><b>6a(2)</b> 116<br><b>6b</b> 0<br><b>6c</b> 48<br><b>6d</b> 164<br><b>6e</b> 0<br><b>6f</b> 164<br><b>6g(1)</b> 139<br><b>6g(2)</b> 163<br><b>6h</b> 13 |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>7</b>                                                                                                                                                                                                                                                                                                                         |

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

2D 2E 2J 2R 3D

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

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

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**a Pension Schedules**

- (1)** ☐ **R** (Retirement Plan Information)
- (2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4)** ☐ **DCG** (Individual Plan Information) – Number Attached \_\_\_\_\_
- (5)** ☐ **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

- (1)** ☒ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **A** (Insurance Information) – Number Attached 1
- (4)** ☒ **C** (Service Provider Information)
- (5)** ☒ **D** (DFE/Participating Plan Information)
- (6)** ☐ **G** (Financial Transaction Schedules)

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2023</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                            |                                        |     |
|--------------------------------------------------------------------------------------------|----------------------------------------|-----|
| For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023 |                                        |     |
| A Name of plan                                                                             | B Three-digit plan number (PN)         | 001 |
| COMPLETE CARE COMMUNITY HEALTH CENTER, INC. RETIREMENT PLAN                                |                                        |     |
| C Plan sponsor's name as shown on line 2a of Form 5500                                     | D Employer Identification Number (EIN) |     |
| COMPLETE CARE COMMUNITY HEALTH CENTER, INC.                                                | 73-1663091                             |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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                |
| JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.) |

| (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     |
| 01-0233346 | 65838         | 129694                                |                                                                             | 01/01/2023              | 12/31/2023 |

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.

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 26587                                | 1767                          |

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 |
| OSAIC WEALTH, INC. 200 LIBERTY FINANCIAL CENTER, 15TH FLOOR NEW YORK, NY 10281                   |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                   | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose       |                       |
| 26087                                         |                                 | BROKER COMMISSION | 4                     |

|                                                                                                  |
|--------------------------------------------------------------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid |
| ALLIED CONSULTANTS, INC. 14768 PIPELINE AVE. CHINO HILLS, CA 91709                               |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |               | (e) Organization code |
|-----------------------------------------------|---------------------------------|---------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose   |                       |
| 500                                           |                                 | TPA FEES PAID | 5                     |

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

ALLIED CONSULTANTS, INC.

14768 PIPELINE AVE.  
CHINO HILLS, CA 91709

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                  | (e) Organization code |
|-----------------------------------------------|---------------------------------|------------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose      |                       |
| 0                                             | 1767                            | TPA COMPENSATION | 5                     |

## (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 |                       |
|                                               |                                 |             |                       |

**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> |  |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

|          |                                                                                                                                                                                                       |           |  |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--|
| <b>b</b> | Premiums paid to carrier .....                                                                                                                                                                        | <b>6b</b> |  |
| <b>c</b> | Premiums due but unpaid at the end of the year.....                                                                                                                                                   | <b>6c</b> |  |
| <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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

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

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

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

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☒ other ▶ **GROUP ANNUITY CONTRACT**

|          |                                                                                                |              |         |
|----------|------------------------------------------------------------------------------------------------|--------------|---------|
| <b>b</b> | Balance at the end of the previous year .....                                                  | <b>7b</b>    | 2810735 |
| <b>c</b> | Additions: (1) Contributions deposited during the year .....                                   | <b>7c(1)</b> | 1624743 |
|          | (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) .....<br>▶ <b>LOAN SECURITY ACCOUNT</b>                              | <b>7c(5)</b> | 80757   |
|          | (6) Total additions.....                                                                       | <b>7c(6)</b> | 1705500 |
| <b>d</b> | Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....                   | <b>7d</b>    | 4516235 |
| <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) .....<br>▶                                                           | <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>    | 4516235 |

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

|                                                                                                                                                   |                 |                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| <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 ..... | <b>10b</b> |  |

Specify nature of costs.

**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. ▶

|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             |                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> | OMB No. 1210-0110                       |
|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             | 2023                                    |
|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             | This Form is Open to Public Inspection. |

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

|                                                                                                                                     |                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <div>A</div> <div>Name of plan</div> <div>COMPLETE CARE COMMUNITY HEALTH CENTER, INC. RETIREMENT PLAN</div>                         | <div>B</div> <div>Three-digit plan number (PN)</div> <div>▶</div> <div>001</div>   |
| <div>C</div> <div>Plan sponsor's name as shown on line 2a of Form 5500</div> <div>COMPLETE CARE COMMUNITY HEALTH CENTER, INC.</div> | <div>D</div> <div>Employer Identification Number (EIN)</div> <div>73-1663091</div> |

Part I

Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1

Information on Persons Receiving Only Eligible Indirect Compensation

- a

Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).....

Yes

No
- b

If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

|                                                                                                            |                                        |
|------------------------------------------------------------------------------------------------------------|----------------------------------------|
| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |                                        |
| JOHN HANCOCK USA                                                                                           | P.O. BOX 600<br>BUFFALO, NY 14201-0600 |
| 01-0233346                                                                                                 |                                        |

|                                                                                                            |
|------------------------------------------------------------------------------------------------------------|
| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|------------------------------------------------------------------------------------------------------------|

|                                                                                                            |
|------------------------------------------------------------------------------------------------------------|
| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
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| (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

JOHN HANCOCK USA

P.O. BOX 600  
BUFFALO, NY 14201-0600

01-0233346

| (b)<br>Service Code(s)        | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 15 28 59<br>60 62 63<br>67 68 | RECORDKEEPER                                                                                      | 464                                                                    | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            |                                                                                                                                                                                 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

(a) Enter name and EIN or address (see instructions)

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

(a) Enter name and EIN or address (see instructions)

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

**Part I Service Provider Information (continued)**

**3.** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |

**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|--------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------|
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |

**Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)**  
(complete as many entries as needed)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p style="text-align: center;"><b>SCHEDULE D</b><br/><b>(Form 5500)</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor<br/>Employee Benefits Security Administration</p> | <p style="text-align: center;"><b>DFE/Participating Plan Information</b></p> <p style="text-align: center; font-size: small;">This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p style="text-align: center; font-weight: bold;">▶ File as an attachment to Form 5500.</p> | <p style="text-align: center; font-size: small;">OMB No. 1210-0110</p> <hr/> <p style="text-align: center; font-size: large; font-weight: bold;">2023</p> <hr/> <p style="text-align: center; font-size: small;">This Form is Open to Public Inspection.</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                |                                                                                               |                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------|
| For calendar plan year 2023 or fiscal plan year beginning <span style="color: blue;">01/01/2023</span> and ending <span style="color: blue;">12/31/2023</span> |                                                                                               |                                       |
| <b>A</b> Name of plan<br><span style="color: blue;">COMPLETE CARE COMMUNITY HEALTH CENTER, INC. RETIREMENT PLAN</span>                                         | <b>B</b> Three-digit plan number (PN) ▶                                                       | <span style="color: blue;">001</span> |
|                                                                                                                                                                |                                                                                               |                                       |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><span style="color: blue;">COMPLETE CARE COMMUNITY HEALTH CENTER, INC.</span>          | <b>D</b> Employer Identification Number (EIN)<br><span style="color: blue;">73-1663091</span> |                                       |

| Part I                                                           | Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)<br>(Complete as many entries as needed to report all interests in DFEs) |               |   |                                                                                                     |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---|-----------------------------------------------------------------------------------------------------|
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2065 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 66626  |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2060 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 94530  |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2055 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 418863 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2050 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 342757 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2045 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 301269 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2040 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 321678 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2035 |                                                                                                                                                                           |               |   |                                                                                                     |
| b Name of sponsor of entity listed in (a): JOHN HANCOCK USA      |                                                                                                                                                                           |               |   |                                                                                                     |
| c EIN-PN                                                         | 01-0233346-000                                                                                                                                                            | d Entity code | P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 367482 |

|                                                                               |                        |                                                                                                            |
|-------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2030       |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 310532 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2025       |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 218511 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET 2020       |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 103435 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: VANGUARD TARGET RET INCOME     |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 358259 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: INVESCO SMALL CAP GROWTH       |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2432   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: MID CAP INDEX FUND             |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 124036 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP INDEX FUND           |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2678   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: 500 INDEX FUND                 |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 416418 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: AMERICAN FUNDS NEW PERSPECTIVE |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2829   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: AF THE GROWTH FUND OF AMERICA  |                        |                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): JOHN HANCOCK USA            |                        |                                                                                                            |
| <b>c</b> EIN-PN 01-0233346-000                                                | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 777426 |

**a** Name of MTIA, CCT, PSA, or 103-12 IE: INVESTMENT COMPANY OF AMERICA

**b** Name of sponsor of entity listed in (a): JOHN HANCOCK USA

|                                |                        |                                                                                                          |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 01-0233346-000 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3092 |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: JOHN HANCOCK BOND FUND

**b** Name of sponsor of entity listed in (a): JOHN HANCOCK USA

|                                |                        |                                                                                                            |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 01-0233346-000 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 144786 |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: TOTAL BOND MARKET FUND

**b** Name of sponsor of entity listed in (a): JOHN HANCOCK USA

|                                |                        |                                                                                                           |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 01-0233346-000 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 42267 |
|--------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Financial Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                             |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>2023</b>                                   |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>This Form is Open to Public Inspection</b> |

|                                                                                                              |                                         |                                                             |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------|
| For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023                   |                                         |                                                             |
| <b>A</b> Name of plan<br>COMPLETE CARE COMMUNITY HEALTH CENTER, INC. RETIREMENT 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<br>COMPLETE CARE COMMUNITY HEALTH CENTER, INC. |                                         |                                                             |
|                                                                                                              |                                         | <b>D</b> Employer Identification Number (EIN)<br>73-1663091 |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**1** Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

| Assets                                                                                             |                 | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....                                                      | <b>1a</b>       | 0                     | 0               |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                            | <b>1b(1)</b>    | 713170                | 866490          |
| <b>(2)</b> Participant contributions .....                                                         | <b>1b(2)</b>    | 0                     | 0               |
| <b>(3)</b> Other .....                                                                             | <b>1b(3)</b>    | 0                     | 0               |
| <b>c</b> General investments:                                                                      |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....   | <b>1c(1)</b>    | 3336                  | 6448            |
| <b>(2)</b> U.S. Government securities .....                                                        | <b>1c(2)</b>    | 0                     | 0               |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                            |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                         | <b>1c(3)(A)</b> | 0                     | 0               |
| <b>(B)</b> All other .....                                                                         | <b>1c(3)(B)</b> | 0                     | 0               |
| <b>(4)</b> Corporate stocks (other than employer securities):                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                         | <b>1c(4)(A)</b> | 0                     | 0               |
| <b>(B)</b> Common .....                                                                            | <b>1c(4)(B)</b> | 0                     | 0               |
| <b>(5)</b> Partnership/joint venture interests .....                                               | <b>1c(5)</b>    | 0                     | 0               |
| <b>(6)</b> Real estate (other than employer real property) .....                                   | <b>1c(6)</b>    | 0                     | 0               |
| <b>(7)</b> Loans (other than to participants) .....                                                | <b>1c(7)</b>    | 0                     | 0               |
| <b>(8)</b> Participant loans .....                                                                 | <b>1c(8)</b>    | 29070                 | 80757           |
| <b>(9)</b> Value of interest in common/collective trusts .....                                     | <b>1c(9)</b>    | 0                     | 0               |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                    | <b>1c(10)</b>   | 2778328               | 4419906         |
| <b>(11)</b> Value of interest in master trust investment accounts .....                            | <b>1c(11)</b>   | 0                     | 0               |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                  | <b>1c(12)</b>   | 0                     | 0               |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....        | <b>1c(13)</b>   | 0                     | 0               |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) ..... | <b>1c(14)</b>   | 0                     | 0               |
| <b>(15)</b> Other .....                                                                            | <b>1c(15)</b>   | 0                     | 0               |

|                                                                           |              |                       |                 |
|---------------------------------------------------------------------------|--------------|-----------------------|-----------------|
| <b>1d</b> Employer-related investments:                                   |              | (a) Beginning of Year | (b) End of Year |
| (1) Employer securities .....                                             | <b>1d(1)</b> | 0                     | 0               |
| (2) Employer real property .....                                          | <b>1d(2)</b> | 0                     | 0               |
| <b>e</b> Buildings and other property used in plan operation .....        | <b>1e</b>    | 0                     | 0               |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e) .....      | <b>1f</b>    | 3523904               | 5373601         |
| <b>Liabilities</b>                                                        |              |                       |                 |
| <b>g</b> Benefit claims payable .....                                     | <b>1g</b>    | 0                     | 0               |
| <b>h</b> Operating payables .....                                         | <b>1h</b>    | 0                     | 0               |
| <b>i</b> Acquisition indebtedness .....                                   | <b>1i</b>    | 0                     | 0               |
| <b>j</b> Other liabilities .....                                          | <b>1j</b>    | 0                     | 0               |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b>    | 0                     | 0               |
| <b>Net Assets</b>                                                         |              |                       |                 |
| <b>l</b> Net assets (subtract line 1k from line 1f) .....                 | <b>1l</b>    | 3523904               | 5373601         |

**Part II Income and Expense Statement**

**2** Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

|                                                                                                            |                 |            |           |
|------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>Income</b>                                                                                              |                 | (a) Amount | (b) Total |
| <b>a Contributions:</b>                                                                                    |                 |            |           |
| (1) Received or receivable in cash from: (A) Employers .....                                               | <b>2a(1)(A)</b> | 857365     |           |
| (B) Participants .....                                                                                     | <b>2a(1)(B)</b> | 420277     |           |
| (C) Others (including rollovers) .....                                                                     | <b>2a(1)(C)</b> | 0          |           |
| (2) Noncash contributions .....                                                                            | <b>2a(2)</b>    |            |           |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            | 1277642   |
| <b>b Earnings on investments:</b>                                                                          |                 |            |           |
| (1) Interest:                                                                                              |                 |            |           |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit) .....              | <b>2b(1)(A)</b> | 0          |           |
| (B) U.S. Government securities .....                                                                       | <b>2b(1)(B)</b> |            |           |
| (C) Corporate debt instruments .....                                                                       | <b>2b(1)(C)</b> |            |           |
| (D) Loans (other than to participants) .....                                                               | <b>2b(1)(D)</b> | 0          |           |
| (E) Participant loans .....                                                                                | <b>2b(1)(E)</b> | 2784       |           |
| (F) Other .....                                                                                            | <b>2b(1)(F)</b> |            |           |
| (G) Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                                     | <b>2b(1)(G)</b> |            | 2784      |
| (2) Dividends: (A) Preferred stock .....                                                                   | <b>2b(2)(A)</b> |            |           |
| (B) Common stock .....                                                                                     | <b>2b(2)(B)</b> |            |           |
| (C) Registered investment company shares (e.g. mutual funds) .....                                         | <b>2b(2)(C)</b> |            |           |
| (D) Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....                         | <b>2b(2)(D)</b> |            |           |
| (3) Rents .....                                                                                            | <b>2b(3)</b>    |            |           |
| (4) Net gain (loss) on sale of assets: (A) Aggregate proceeds .....                                        | <b>2b(4)(A)</b> |            |           |
| (B) Aggregate carrying amount (see instructions) .....                                                     | <b>2b(4)(B)</b> |            |           |
| (C) Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....                         | <b>2b(4)(C)</b> |            |           |
| (5) Unrealized appreciation (depreciation) of assets: (A) Real estate .....                                | <b>2b(5)(A)</b> |            |           |
| (B) Other .....                                                                                            | <b>2b(5)(B)</b> |            |           |
| (C) Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....                | <b>2b(5)(C)</b> |            |           |

|                                                                                                 |        | (a) Amount | (b) Total |
|-------------------------------------------------------------------------------------------------|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts.....                               | 2b(6)  |            | 0         |
| (7) Net investment gain (loss) from pooled separate accounts.....                               | 2b(7)  |            | 650871    |
| (8) Net investment gain (loss) from master trust investment accounts.....                       | 2b(8)  |            | 0         |
| (9) Net investment gain (loss) from 103-12 investment entities.....                             | 2b(9)  |            | 0         |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) ..... | 2b(10) |            | 0         |
| c Other income .....                                                                            | 2c     |            | 0         |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total .....               | 2d     |            | 1931297   |

**Expenses**

|                                                                                      |        |       |       |
|--------------------------------------------------------------------------------------|--------|-------|-------|
| e Benefit payment and payments to provide benefits:                                  |        |       |       |
| (1) Directly to participants or beneficiaries, including direct rollovers .....      | 2e(1)  | 30072 |       |
| (2) To insurance carriers for the provision of benefits.....                         | 2e(2)  | 0     |       |
| (3) Other .....                                                                      | 2e(3)  | 0     |       |
| (4) Total benefit payments. Add lines 2e(1) through (3) .....                        | 2e(4)  |       | 30072 |
| f Corrective distributions (see instructions) .....                                  | 2f     |       | 0     |
| g Certain deemed distributions of participant loans (see instructions) .....         | 2g     |       | 0     |
| h Interest expense .....                                                             | 2h     |       | 0     |
| i Administrative expenses:                                                           |        |       |       |
| (1) Salaries and allowances .....                                                    | 2i(1)  | 0     |       |
| (2) Contract administrator fees.....                                                 | 2i(2)  | 51028 |       |
| (3) Recordkeeping fees.....                                                          | 2i(3)  | 0     |       |
| (4) IQPA audit fees.....                                                             | 2i(4)  | 0     |       |
| (5) Investment advisory and investment management fees .....                         | 2i(5)  | 0     |       |
| (6) Bank or trust company trustee/custodial fees .....                               | 2i(6)  | 0     |       |
| (7) Actuarial fees .....                                                             | 2i(7)  | 0     |       |
| (8) Legal fees .....                                                                 | 2i(8)  | 0     |       |
| (9) Valuation/appraisal fees .....                                                   | 2i(9)  | 0     |       |
| (10) Other trustee fees and expenses .....                                           | 2i(10) | 0     |       |
| (11) Other expenses .....                                                            | 2i(11) | 500   |       |
| (12) Total administrative expenses. Add lines 2i(1) through (11) .....               | 2i(12) |       | 51528 |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | 2j     |       | 81600 |

**Net Income and Reconciliation**

|                                                          |       |  |         |
|----------------------------------------------------------|-------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d ..... | 2k    |  | 1849697 |
| l Transfers of assets:                                   |       |  |         |
| (1) To this plan .....                                   | 2l(1) |  |         |
| (2) From this plan .....                                 | 2l(2) |  |         |

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **PDM, LLP**

(2) EIN: **33-0783700**

**d** The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

**Part IV Compliance Questions**

**4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

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? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) .....                 | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <b>92863</b>  |
| <b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) ..... | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) .....                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) .....                                                                                                                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <b>375000</b> |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                                                                                                   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |               |
| <b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) .....                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |               |
| <b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. ....                                                                                                                         | <input type="checkbox"/>            | <input type="checkbox"/>            |               |

**5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ..... ☐ Yes ☒ No  
If "Yes," enter the amount of any plan assets that reverted to the employer this year \_\_\_\_\_.

**5b** 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>5b(1)</b> Name of plan(s) | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> PN(s) |
|------------------------------|---------------------|--------------------|
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |

**5c** Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_\_.



**Complete Care Community Health Center, Inc. Retirement  
Plan**

**AUDITED FINANCIAL STATEMENTS AND  
SUPPLEMENTAL SCHEDULES**

**DECEMBER 31, 2023 AND 2022**

*with*

**INDEPENDENT AUDITORS' REPORT THEREON**

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# **COMPLETE CARE COMMUNITY HEALTH CENTER, INC.**

## **RETIREMENT PLAN**

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## Independent Auditors' Report

To the Administrative Committee of  
Complete Care Community Health Center, Inc. Retirement Plan

### *Scope and Nature of the ERISA Section 103(a)(3)(C) Audit*

We have performed audits of the financial statements of Complete Care Community Health Center, Inc. Retirement Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as permitted by ERISA Section 103(a)(3)(C) ("ERISA Section 103(a)(3)(C) audit"). The financial statements comprise the statements of net assets available for benefits as of December 31, 2023 and 2022, and the related statement of changes in net assets available for benefits for the year ended December 31, 2023, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of the Plan's Financial Statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the Plan ("investment information") by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA ("qualified institution").

Management has obtained certifications from a qualified institution as of December 31, 2023 and 2022 and for the year ended December 31, 2023, stating that the certified investment information, as described in Note 5 to the financial statements, is complete and accurate.

### *Opinion*

In our opinion, based on our audits and on the procedures performed as described in the Auditors' Responsibilities for the Audit of the Financial Statements section:

- the amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- the information in the accompanying financial statements related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

### ***Basis for Opinion***

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (“GAAS”). Our responsibilities under those standards are further described in the Auditors’ Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

### ***Responsibilities of Management for the Financial Statements***

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are issued.

Management is also responsible for maintaining a current Plan instrument, including all Plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

### ***Auditors' Responsibilities for the Audit of the Financial Statements***

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

Our audits did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

***Other Matters - Supplemental Schedules Required by ERISA***

The Supplemental Schedule of Assets (Held at End of Year) as of December 31, 2023 and Schedule of Delinquent Participant Contributions for the year ended December 31, 2023, are presented for purposes of additional analysis and are not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, other than the information agreed to or derived from the certified investment information, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion:

- the form and content of the supplemental schedules, other than the information in the supplemental schedules that agreed to or is derived from the certified investment information, is presented, in all material respects, in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.
- the information in the supplemental schedules related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

*PDM, LLP*

Torrance, California  
October 9, 2024

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

### STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31,

---

|                                          | <u>2023</u>         | <u>2022</u>         |
|------------------------------------------|---------------------|---------------------|
| <b>ASSETS</b>                            |                     |                     |
| <b>INVESTMENTS</b>                       |                     |                     |
| Pooled separate accounts, at fair value  | <u>\$ 4,419,906</u> | <u>\$ 2,778,328</u> |
| <b>RECEIVABLES</b>                       |                     |                     |
| Sponsor contributions receivable         | 866,490             | 713,170             |
| Notes receivable from participants       | <u>80,757</u>       | <u>29,070</u>       |
|                                          | <u>947,247</u>      | <u>742,240</u>      |
| <b>CASH, interest-bearing</b>            | <u>6,448</u>        | <u>3,336</u>        |
| <b>NET ASSETS AVAILABLE FOR BENEFITS</b> | <u>\$ 5,373,601</u> | <u>\$ 3,523,904</u> |

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*The accompanying notes are an integral part  
of these financial statements*

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

### STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS YEAR ENDED DECEMBER 31, 2023

---

#### ADDITIONS TO NET ASSETS ATTRIBUTABLE TO:

##### INVESTMENT INCOME

|                                                                              |            |
|------------------------------------------------------------------------------|------------|
| Net appreciation in fair value of investments in pooled<br>separate accounts | \$ 650,871 |
|------------------------------------------------------------------------------|------------|

##### INTEREST INCOME ON NOTES RECEIVABLE FROM PARTICIPANTS

|       |
|-------|
| 2,784 |
|-------|

##### CONTRIBUTIONS

|              |                  |
|--------------|------------------|
| Participants | 420,277          |
| Sponsor      | 857,365          |
|              | <u>1,277,642</u> |

|                 |                  |
|-----------------|------------------|
| TOTAL ADDITIONS | <u>1,931,297</u> |
|-----------------|------------------|

#### DEDUCTIONS FROM NET ASSETS ATTRIBUTABLE TO:

|                                   |               |
|-----------------------------------|---------------|
| Benefits paid to participants     | 30,072        |
| Administrative and other expenses | <u>51,528</u> |

|                  |               |
|------------------|---------------|
| TOTAL DEDUCTIONS | <u>81,600</u> |
|------------------|---------------|

#### CHANGE IN NET ASSETS AVAILABLE FOR BENEFITS

|           |
|-----------|
| 1,849,697 |
|-----------|

#### NET ASSETS AVAILABLE FOR BENEFITS, beginning of year

|                  |
|------------------|
| <u>3,523,904</u> |
|------------------|

#### NET ASSETS AVAILABLE FOR BENEFITS, end of year

|                     |
|---------------------|
| <u>\$ 5,373,601</u> |
|---------------------|

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*The accompanying notes are an integral part  
of these financial statements*

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

---

### NOTE 1 - DESCRIPTION OF PLAN

The following description of the Complete Care Community Health Center, Inc. Retirement Plan (the “Plan”) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

**General** - The Plan was adopted by the Sponsor on January 1, 2017. The Plan is a defined contribution plan covering eligible employees of Complete Care Community Health Center, Inc. (the “Organization” or “Sponsor”). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”) and subsequent amendments.

**Plan administration** - The Organization is the Plan Sponsor and Plan administrator and is responsible for oversight of the Plan and for monitoring investment activity. Allied Consultants, Inc. (the “TPA”) is the Plan’s third-party administrator. John Hancock Life Insurance Company (the “Custodian”) is the custodian of the Plan’s assets and record-keeper and is responsible for maintaining individual participant account balances and holding investments.

**Tax status** - The Plan document is a non-standardized pre-approved 401(k) profit sharing plan offered by the TPA. The Internal Revenue Service (“IRS”) has determined and informed the TPA by a favorable opinion letter dated June 30, 2020, that the non-standardized profit sharing plan is designed in accordance with applicable sections of the Internal Revenue Code (the “Code”). The Plan has been amended since adoption; however, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the Code.

**Participation** - An employee is eligible to make contributions to the Plan upon attaining the age of 21 and completion of one year of service. Employees are eligible for Sponsor’s discretionary profit sharing and safe harbor contributions upon attaining the age of 21 and completion of one year of consecutive service. Eligible employees may enter the Plan semi-annually after they satisfy the eligibility requirements.

**Participant contributions** - Participant salary reduction contributions to the Plan may be deferred as a flat amount or as a percentage of regular compensation. However, the total of these salary deferral contributions may not, in any calendar year, exceed limitations set by the Code. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans.

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

---

### NOTE 1 - DESCRIPTION OF PLAN, Continued

**Sponsor contributions** - The Sponsor may make discretionary non-elective profit sharing contributions to the Plan annually. Discretionary profit sharing contributions are allocated as of the last day of the Plan year to eligible participants and are allocated based on a discretionary formula. For the year ended December 31, 2023, the Sponsor contributed \$689,982 to the Plan for discretionary profit sharing contributions. The Sponsor may also make annual ADP test safe harbor contributions equal to 3% of the employees' compensation. Safe harbor contributions are allocated as of the last day of the Plan year to eligible participants. For the year ended December 31, 2023, the Sponsor contributed \$176,508 to the Plan for safe harbor contributions. The discretionary profit sharing and safe harbor contributions totaling \$866,490 and \$713,170 are included in Sponsor contributions receivable at December 31, 2023 and 2022, respectively.

**Participant accounts** - Separate accounts are maintained for each participant's deferred compensation, rollover contributions, and the Sponsor's contributions. All gains, income, or losses are allocated separately to each participant's account, based on the performance of the investments within that account. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account. Participants may direct their contributions into any or all of the investment accounts with the Custodian.

**Vesting** - Participants are fully vested in their contributions and Sponsor safe harbor contributions plus actual earnings thereon. The Sponsor discretionary profit sharing contributions, plus actual earnings thereon, vest ratably over six years of service in which the employee works at least 1,000 hours during each year, as follows:

| <u>Year of Service</u> | <u>Percent Vested</u> |
|------------------------|-----------------------|
| Less than 2            | 0%                    |
| 2                      | 20%                   |
| 3                      | 40%                   |
| 4                      | 60%                   |
| 5                      | 80%                   |
| 6                      | 100%                  |

**Forfeitures** - Non-vested Sponsor profit sharing contributions forfeited by participants upon termination are available to reduce future payments of the Sponsor's contributions or Plan administration fees. The total available forfeiture balance to reduce Sponsor contributions as of December 31, 2023 and 2022, was \$6,448 and \$3,336, respectively. Forfeitures amounting to \$9,125 and \$0 were used to reduce Sponsor contributions during the year ended December 31, 2023 and 2022.

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# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

---

### NOTE 1 - DESCRIPTION OF PLAN, Continued

**Payment of benefits** - Upon termination of employment due to termination of service, death, disability, or retirement, a participant may elect to receive either a lump-sum distribution or direct transfer to either an Individual Retirement Account or a qualified retirement plan. Other withdrawals from the Plan can be made under certain circumstances, as defined in the Plan agreement. In-service distributions are not permitted by the Plan.

**Hardship withdrawals** - In the event a participant experiences a financial hardship as defined in the Plan agreement, the participant may be eligible to request a hardship withdrawal. Hardship withdrawals are only available on salary reduction contributions under the Plan. There were no hardship withdrawals during the year ended December 31, 2023.

**Notes receivable from participants** - Participants may borrow against their accounts in amounts not less than \$1,000 and not to exceed the lesser of \$50,000 or 50% of their vested account balance. Loans to participants are collateralized by the participant's vested account balance. Repayment schedules for notes receivable from participants are as agreed upon by the participant and the Plan administrator, but cannot exceed repayment terms defined by the Code. Generally, notes mature within five years unless the note is for the purchase of a personal residence. Principal and interest is paid ratably through payroll deductions. Interest on new notes is determined by the Plan administrator as the published prime lending rate, at the time of origination.

**Plan termination** - Although it has not expressed an intent to do so, the Sponsor reserves the right under the Plan, to cease contributions and terminate the Plan, subject to action by the Sponsor's Board of Directors and subject to the provisions of ERISA and the Code. Upon termination of the Plan, all participants become 100% vested in their accounts.

### NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Basis of presentation** - The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

**Use of estimates** - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan's administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

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### NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, Continued

**Valuation of investments** - Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

**Fair value measurements** - The Plan measures fair value under a framework that utilizes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of inputs which prioritize the inputs used in measuring fair value are:

Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2: Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

---

### NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, Continued

**Realized and unrealized appreciation (depreciation)** - Realized and unrealized appreciation (depreciation) is based on the market values of the assets at the end of the Plan year compared to the market values of the assets at the beginning of the Plan year, or at the time of purchase for assets purchased/exchanged during the Plan year. In the Statement of Changes in Net Assets Available for Benefits, the Plan presents the net appreciation or depreciation in the fair value of investments, which consists of realized gains or losses and unrealized market value appreciation or depreciation of investments.

**Notes receivable from participants** - Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed when they are incurred. No allowance for credit losses has been recorded as of December 31, 2023 and 2022. If a participant ceases to make loan repayments and the Plan administrator deems the participant loan to be in default, the participant loan balance is reduced and a benefit payment is recorded. Outstanding notes receivable from participants at December 31, 2023 bear interest at rates between 4.25% and 9.50% and mature through July 2033.

**Participant distributions** - Benefits paid to participants are recorded when paid.

**Plan expenses** - Non-investment costs and certain administrative expenses of the Plan are paid by the Sponsor, which is a party-in-interest. These expenses are not reflected in the accompanying financial statements and constitute exempt transactions under ERISA. Investment service fees are paid by the Plan and are netted against the related investment income. Certain administrative expenses are paid by the Plan.

**Income taxes** - Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the taxing authorities. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2023 and 2022, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan administrator believes it is no longer subject to income tax examination for years prior to 2020.

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2023 AND 2022

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### NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, Continued

**Risks and uncertainties** - The Plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Market risks include global events which could impact the value of investment securities, such as a pandemic or international conflict. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the Statements of Net Assets Available for Benefits.

During the year ended December 31, 2022 and through August 2023, the Plan did not meet ERISA's bonding requirements. ERISA requires that employee benefit plans to be covered by a fidelity bond to protect the Plan from losses due to fraud or dishonesty. As a result, the fiduciary and trustee of the Plan can be held personally liable for losses that should have been covered by a fidelity bond. Effective September 2023, the Plan was covered by a fidelity bond to insure against losses due to fraud or dishonesty.

**Subsequent events** - Subsequent events have been evaluated by the Sponsor through October 9, 2024, which is the date these financial statements were available to be issued.

### NOTE 3 - INVESTMENTS AND FAIR VALUE MEASUREMENTS

The following is a description of the valuation methodologies used for the assets measured at fair value. There have been no changes in methodologies used as of December 31, 2023 and 2022.

**Pooled separate accounts** - The fair values of participation units held in pooled separate accounts are based on the net asset values reported by the fund managers as of financial statement dates and recent transaction prices. Each of the subaccounts of the John Hancock Life Insurance Company pooled separate accounts invests in a single, open-ended mutual fund which is generally identified in the name of the pooled separate sub-account. Each pooled separate sub-account provides for daily redemptions by the Plan with no advance notice requirements, and has redemption prices that are determined by the fund's net asset value ("NAV") per unit. The pooled separate accounts are measured at fair value using NAV (or its equivalent) as a practical expedient. These investments have no unfunded commitments.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan administrator believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

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# **COMPLETE CARE COMMUNITY HEALTH CENTER, INC.**

## **RETIREMENT PLAN**

**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

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### **NOTE 3 - INVESTMENTS AND FAIR VALUE MEASUREMENTS, Continued**

As of December 31, 2023 and 2022, all fair value investments were valued using NAV as a practical expedient, and accordingly, no fair value hierarchy table was presented.

### **NOTE 4 - PARTY-IN-INTEREST TRANSACTIONS**

Parties-in-interest, by definition, include a plan sponsor or employee, fiduciaries (including those who provide investment advice or who have discretionary control over Plan assets), and those who provide services to the Plan. Notes receivable from participants qualify as exempt party-in-interest transactions. Plan investments include certain investments in pooled separate accounts' shares managed by the Custodian as of December 31, 2023 and 2022. Transactions with these entities qualify as exempt party-in-interest transactions.

Fees incurred by the Plan for the investment management services are included in net depreciation in fair value of investments, as they are paid through revenue sharing, rather than a direct payment.

### **NOTE 5 - INFORMATION CERTIFIED BY THE CUSTODIAN OF PLAN ASSETS (Unaudited)**

Management has elected to have the 2023 audit of the Plan performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, John Hancock Life Insurance Company, the Custodian of the Plan, has certified that the following investment information is complete and accurate:

- All amounts included as investments and notes receivable from participants in the Statements of Net Assets Available for Benefits as of December 31, 2023 and 2022;
- Investment income included in the Statement of Changes in Net Assets Available for Benefits for the year ended December 31, 2023; and
- All information in the Supplemental Schedule of Assets (Held at End of Year) as of December 31, 2023.

# **COMPLETE CARE COMMUNITY HEALTH CENTER, INC.**

## **RETIREMENT PLAN**

**NOTES TO FINANCIAL STATEMENTS**  
**DECEMBER 31, 2023 AND 2022**

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### **NOTE 6 - PROHIBITED TRANSACTIONS**

During the year ended December 31, 2023, the Plan failed to comply with the regulations concerning the timely remittance of participants' contributions to the trust containing assets for the Plan, which is a prohibited transaction under ERISA regulations. Accordingly, participants' contributions, including loan repayments, totaling \$92,863 were remitted to the Plan late as described in the supplemental schedule (Schedule H, Part IV, Line 4(a) - Schedule of Delinquent Participant Contributions). The principal amount of the contributions has been remitted to the Plan. However, in order to complete the correction, lost earnings must also be remitted by the employer. The Plan Sponsor will compute the lost earnings and will remit to the Plan in 2024.

## **SUPPLEMENTAL SCHEDULES**

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# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
SCHEDULE H, PART IV, LINE 4(i)  
EIN: 73-1663091 PLAN NO. 001  
DECEMBER 31, 2023

| (a)                                   | (b)<br>Identity of issuer,<br>borrower, lessor, or<br>similar party | (c)<br>Description of investment, including<br>maturity date, rate of interest,<br>collateral, and par or maturity value | (d)<br>Cost | (e)<br>Current<br>Value |
|---------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------|
| <b>Pooled separate accounts</b>       |                                                                     |                                                                                                                          |             |                         |
| *                                     | John Hancock                                                        | American Funds The Growth Fund of America                                                                                | \$          | 777,426                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2055                                                                                          |             | 418,863                 |
| *                                     | John Hancock                                                        | 500 Index Fund                                                                                                           |             | 416,418                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2035                                                                                          |             | 367,482                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement Income                                                                                        |             | 358,259                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2050                                                                                          |             | 342,757                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2040                                                                                          |             | 321,678                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2030                                                                                          |             | 310,532                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2045                                                                                          |             | 301,269                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2025                                                                                          |             | 218,511                 |
| *                                     | John Hancock                                                        | John Hancock Bond Fund                                                                                                   |             | 144,786                 |
| *                                     | John Hancock                                                        | Mid Cap Index Fund                                                                                                       |             | 124,036                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2020                                                                                          |             | 103,435                 |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2060                                                                                          |             | 94,530                  |
| *                                     | John Hancock                                                        | Vanguard Target Retirement 2065                                                                                          |             | 66,626                  |
| *                                     | John Hancock                                                        | Total Bond Market Fund                                                                                                   |             | 42,267                  |
| *                                     | John Hancock                                                        | American Funds The Investment Company of America                                                                         |             | 3,092                   |
| *                                     | John Hancock                                                        | American Funds New Perspective                                                                                           |             | 2,829                   |
| *                                     | John Hancock                                                        | Small Cap Index Fund                                                                                                     |             | 2,678                   |
| *                                     | John Hancock                                                        | Invesco Small Cap Growth                                                                                                 |             | 2,432                   |
| <b>Total pooled separate accounts</b> |                                                                     |                                                                                                                          |             | 4,419,906               |
| <b>Total investments held</b>         |                                                                     |                                                                                                                          | \$          | 4,419,906               |
| *                                     | Notes receivable from participants                                  | Maturing through July 2033; bearing interest between 4.25% and 9.50%; collateralized by participant accounts.            | \$          | 80,757                  |

**Note:** Cost information for investments have been excluded as all investments are participant directed.

\* Represents a party-in-interest.

*See independent auditors' report*

# COMPLETE CARE COMMUNITY HEALTH CENTER, INC.

## RETIREMENT PLAN

### SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS

#### SCHEDULE H, PART IV, LINE 4(a)

#### EIN: 73-1663091 PLAN NO. 001

#### YEAR ENDED DECEMBER 31, 2023

| Participant<br>Contributions<br>Transferred Late to the<br>Plan                                              | Total That Constitute Nonexempt Prohibited Transactions |                                            |                                             | Total Fully Corrected<br>Under Voluntary<br>Fiduciary Correction<br>Program (VFCP) and<br>Prohibited Transaction<br>Exemption 2002-51 |
|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| Check Here if Late<br>Participant Loan<br>Repayments are<br>Included:<br><input checked="" type="checkbox"/> | Contributions Not<br>Corrected                          | Contributions Corrected<br>Outside of VFCP | Contributions Pending<br>Correction in VFCP |                                                                                                                                       |
| \$ 92,863                                                                                                    | \$ 92,863                                               | \$ -                                       | \$ -                                        | \$ -                                                                                                                                  |

*See independent auditors' report*

|                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br><br>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b), and 6058(a) of the Internal Revenue Code (the Code).<br><br>▶ <b>Complete all entries in accordance with the Instructions to the Form 5500.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2023</b><br><br><b>This Form is Open to Public Inspection</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|

|                                                                                                     |                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I Annual Report Identification Information</b>                                              |                                                                                                                                                                                                                       |
| For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023          |                                                                                                                                                                                                                       |
| A This return/report is for:                                                                        | <input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) |
| B This return/report is:                                                                            | <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) _____                                                                                                            |
|                                                                                                     | <input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report;                                                                                                                   |
|                                                                                                     | <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).                                                                                    |
| C If the plan is a collectively-bargained plan, check here . . . . .                                | <input type="checkbox"/>                                                                                                                                                                                              |
| D Check box if filing under:                                                                        | <input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program;                                                                               |
|                                                                                                     | <input type="checkbox"/> special extension (enter description) _____                                                                                                                                                  |
| E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here . . . . . | <input type="checkbox"/>                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II Basic Plan Information --- enter all requested information</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                             |
| <b>1a</b> Name of plan<br>Complete Care Community Health Center, Inc. Retirement Plan                                                                                                                                                                                                                                                                                                    | <b>1b</b> Three-digit plan number (PN) ▶ 001                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                          | <b>1c</b> Effective date of plan<br>01/01/2017                                                                                                                                              |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (If foreign, see instructions)<br><br>Complete Care Community Health Center, Inc.<br><br>3000 S. Robertson Blvd., Ste. #280<br><br>US Los Angeles CA 90034 | <b>2b</b> Employer Identification Number (EIN)<br>73-1663091<br><br><b>2c</b> Plan Sponsor's telephone number<br>(310) 730-6362<br><br><b>2d</b> Business code (see instructions)<br>621111 |

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

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

|                  |                                                                                     |           |                                                              |
|------------------|-------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------|
| <b>SIGN HERE</b> |  | 9/30/2024 | Yury Akopyan                                                 |
|                  | Signature of plan administrator                                                     | Date      | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |  | 9/30/2024 | Yury Akopyan                                                 |
|                  | Signature of employer/plan sponsor                                                  | Date      | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |                                                                                     |           |                                                              |
|                  | Signature of DFE                                                                    | Date      | Enter name of individual signing as DFE                      |

|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                          | <b>3b</b> Administrator's EIN<br><br><b>3c</b> Administrator's telephone number<br><br><div style="background-color: #cccccc; height: 20px; width: 100%;"></div> |
| <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 and the plan name and the plan number from the last return/report:<br><b>a</b> Sponsor's name<br><b>c</b> Plan name                                                         | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                           | <b>5</b> 157                                                                                                                                                     |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).                                                                                                                                                                                          |                                                                                                                                                                  |
| <b>a(1)</b> Total number of active participants at the beginning of the plan year                                                                                                                                                                                                                                                                 | <b>6a(1)</b> 120                                                                                                                                                 |
| <b>a(2)</b> Total number of active participants at the end of the plan year                                                                                                                                                                                                                                                                       | <b>6a(2)</b> 116                                                                                                                                                 |
| <b>b</b> Retired or separated participants receiving benefits                                                                                                                                                                                                                                                                                     | <b>6b</b> 0                                                                                                                                                      |
| <b>c</b> Other retired or separated participants entitled to future benefits                                                                                                                                                                                                                                                                      | <b>6c</b> 48                                                                                                                                                     |
| <b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c                                                                                                                                                                                                                                                                                                    | <b>6d</b> 164                                                                                                                                                    |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits                                                                                                                                                                                                                                              | <b>6e</b> 0                                                                                                                                                      |
| <b>f</b> Total. Add lines 6d and 6e                                                                                                                                                                                                                                                                                                               | <b>6f</b> 164                                                                                                                                                    |
| <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)                                                                                                                                                                                                | <b>6g(1)</b> 139                                                                                                                                                 |
| <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)                                                                                                                                                                                                      | <b>6g(2)</b> 163                                                                                                                                                 |
| <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested                                                                                                                                                                                                              | <b>6h</b> 13                                                                                                                                                     |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)                                                                                                                                                                                                                    | <b>7</b>                                                                                                                                                         |
| <b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:<br>2D 2E 2J 2R 3D<br><br><b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: |                                                                                                                                                                  |

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

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>a Pension Schedules</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>b General Schedules</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| (1) <input type="checkbox"/> R (Retirement Plan Information)<br>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary<br>(4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____<br>(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information) | (1) <input checked="" type="checkbox"/> H (Financial Information)<br>(2) <input type="checkbox"/> I (Financial Information - Small Plan)<br>(3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>1</u><br>(4) <input checked="" type="checkbox"/> C (Service Provider Information)<br>(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)<br>(6) <input type="checkbox"/> G (Financial Transaction Schedules) |

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

[illegible]

## Schedule H, Line 4

## Schedule of Delinquent Participant Contributions

For the Plan Year Beginning 01/01/2023 and Ending 12/31/2023

Name of Plan: Complete Care Community Health Center, Inc. Retirement Plan

Employer Identification Number: 73-1663091 Three-digit plan number: 001

[illegible]