

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2023

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

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

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 07/01/2023 and ending 06/30/2024

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan... [X] a single-employer plan [] a DFE (specify)
B This return/report is: [] the first return/report [] the final return/report [] an amended return/report [] a short plan year return/report...
C If the plan is a collectively-bargained plan, check here... []
D Check box if filing under: [X] Form 5558 [] automatic extension [] the DFVC program [] special extension...
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here... []

Part II Basic Plan Information—enter all requested information

1a Name of plan: 403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS
1b Three-digit plan number (PN): 001
1c Effective date of plan: 07/01/1997
2a Plan sponsor's name (employer, if for a single-employer plan): EASTERN PANHANDLE MENTAL HEALT
2b Employer Identification Number (EIN): 23-7116164
2c Plan Sponsor's telephone number: 304-263-8954
2d Business code (see instructions): 621420

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2023) v. 230707

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 297 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6a(1) | 233 |
| | 6a(2) | 264 |
| | 6b | 9 |
| | 6c | 35 |
| | 6d | 308 |
| | 6e | 0 |
| | 6f | 308 |
| | 6g(1) | 168 |
| 6g(2) | 149 | |
| 6h | 5 | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)..... | 7 | |

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
 2G 2J 2K 2E 2T

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

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|------------|
| A Name of plan 403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS | | B Three-digit plan number (PN) ▶ | 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 EASTERN PANHANDLE MENTAL HEALT | | D Employer Identification Number (EIN) 23-7116164 | |

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

MUTUAL OF AMERICA

| (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 |
| 13-1614399 | 88668 | 007276J | 308 | 07/01/2023 | 06/30/2024 |

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 |
|---------------------------------------------|--------------------------------------|

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

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

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

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

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

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

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|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
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|-----------------------------------------------|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

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

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

(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. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 418445 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 4296287 |
| 6 | Contracts With Allocated Funds: | |
| a | State the basis of premium rates ▶ | |
| b | Premiums paid to carrier | 6b |
| c | Premiums due but unpaid at the end of the year..... | 6c |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | 6d |
| e | Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | |
| f | If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | |
| 7 | Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | |
| a | Type of contract: (1) <input checked="" type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 433525 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) 41706 |
| | (2) Dividends and credits | 7c(2) 0 |
| | (3) Interest credited during the year | 7c(3) 9373 |
| | (4) Transferred from separate account..... | 7c(4) 31509 |
| | (5) Other (specify below) | 7c(5) 12 |
| | ▶ ROLLOVER, LOANS, FORFEITURES | |
| | (6) Total additions | 7c(6) 82600 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 516125 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 94165 |
| | (2) Administration charge made by carrier | 7e(2) 251 |
| | (3) Transferred to separate account..... | 7e(3) 0 |
| | (4) Other (specify below) | 7e(4) 3264 |
| ▶ FORFEITURES | | |
| | (5) Total deductions | 7e(5) 97680 |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | 7f 418445 |

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 <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts:

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------|---|
| a Premiums: (1) Amount received | | 9a(1) | |
| (2) Increase (decrease) in amount due but unpaid..... | | 9a(2) | |
| (3) Increase (decrease) in unearned premium reserve | | 9a(3) | |
| (4) Earned ((1) + (2) - (3))..... | | 9a(4) | 0 |
| b Benefit charges (1) Claims paid..... | | 9b(1) | |
| (2) Increase (decrease) in claim reserves | | 9b(2) | |
| (3) Incurred claims (add (1) and (2))..... | | 9b(3) | 0 |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies..... | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | 9c(1)(H) | | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves..... | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |
| 10 Nonexperience-rated contracts: | | | |
| a Total premiums or subscription charges paid to carrier | | 10a | |
| 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 | | 10b | |

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. ▶

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| A Name of plan 403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS | B Three-digit plan number (PN) ▶ 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 EASTERN PANHANDLE MENTAL HEALT | D Employer Identification Number (EIN) 23-7116164 |

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

EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|-------------------|----------------------|----------------------------------------------|------------------------------------------------------------------------------------|--------------------------------|-------------------|
| | | | | (f) From | (g) To |
| 13-5570651 | 62944 | 775946-000 | 51 | 07/01/2023 | 06/30/2024 |

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 |
|---------------------------------------------|--------------------------------------|

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

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

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

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

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

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

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

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

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

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

| (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. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 433891 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 537195 |
| 6 | Contracts With Allocated Funds: | |
| a | State the basis of premium rates ▶ | |
| b | Premiums paid to carrier | 6b |
| c | Premiums due but unpaid at the end of the year..... | 6c |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | 6d |
| e | Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | |
| f | If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | |
| 7 | Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | |
| a | Type of contract: (1) <input checked="" type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 464350 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) 0 |
| | (2) Dividends and credits | 7c(2) 0 |
| | (3) Interest credited during the year | 7c(3) 13320 |
| | (4) Transferred from separate account..... | 7c(4) 0 |
| | (5) Other (specify below) | 7c(5) |
| | (6) Total additions | 7c(6) 13320 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 477670 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 43512 |
| | (2) Administration charge made by carrier | 7e(2) 267 |
| | (3) Transferred to separate account..... | 7e(3) 0 |
| | (4) Other (specify below) | 7e(4) |
| (5) Total deductions | 7e(5) 43779 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | 7f 433891 |

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | | | |
|----------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|---|
| a | Premiums: (1) Amount received | 9a(1) | | |
| | (2) Increase (decrease) in amount due but unpaid..... | 9a(2) | | |
| | (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| | (4) Earned ((1) + (2) - (3))..... | | 9a(4) | 0 |
| b | Benefit charges (1) Claims paid..... | 9b(1) | | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | | |
| | (3) Incurred claims (add (1) and (2))..... | | 9b(3) | 0 |
| | (4) Claims charged | | 9b(4) | |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| | (A) Commissions | 9c(1)(A) | | |
| | (B) Administrative service or other fees | 9c(1)(B) | | |
| | (C) Other specific acquisition costs | 9c(1)(C) | | |
| | (D) Other expenses | 9c(1)(D) | | |
| | (E) Taxes | 9c(1)(E) | | |
| | (F) Charges for risks or other contingencies..... | 9c(1)(F) | | |
| | (G) Other retention charges | 9c(1)(G) | | |
| | (H) Total retention | | 9c(1)(H) | 0 |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)..... | | 9c(2) | |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) | |
| | (2) Claim reserves | | 9d(2) | |
| | (3) Other reserves..... | | 9d(3) | |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e | |

10 Nonexperience-rated contracts:

| | | | |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| a | Total premiums or subscription charges paid to carrier | 10a | |
| 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 | 10b | |

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. ▶

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

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan 403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS | B Three-digit plan number (PN) ▶ | 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 EASTERN PANHANDLE MENTAL HEALT | D Employer Identification Number (EIN) 23-7116164 | |

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

| | |
|-----|-----------------------------------------------|
| DWS | 210 WEST 10TH STREET KANSAS CITY, MO 64105 |
|-----|-----------------------------------------------|

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

| | |
|----------------------|------------------------------------------|
| FIDELITY INVESTMENTS | 82 DEVONSHIRE STREET BOSTON, MA 02109 |
|----------------------|------------------------------------------|

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

| | |
|---------------|---------------------------------------|
| GOLDMAN SACHS | 200 WEST STREET NEW YORK, NY 10282 |
|---------------|---------------------------------------|

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

| | |
|-------------------|------------------------------------|
| MUTUAL OF AMERICA | 320 PARK AVE NEW YORK, NY 10022 |
|-------------------|------------------------------------|

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

NEUBERGER BERMAN

1290 AVENUE OF THE AMERICAS
NEW YORK, NY 10104

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

INVESCO

11 GREENWAY PLAZA
STE. 2500
HOUSTON, TX 77046

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

T. ROWE PRICE

100 EAST PRATT STREET
BALTIMORE, MD 21202

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

VANGUARD

100 VANGUARD BOULEVARD
MALVERN, PA 19355

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

AMERICAN CENTURY INVESTMENTS

P.O. BOX 419200
4500 MAIN STREET
KANSAS CITY, MO 64141

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

MFS

111 HUNTINGTON AVENUE
BOSTON, MA 02199

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

DELAWARE FUNDS BY MACQUARIE

PO BOX 9876
PROVIDENCE, RI 02940

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

VICTORY CAPITAL MANAGEMENT INC.

15935 LA CANTERA PARKWAY
BUILDING TWO
SAN ANTONIO, TX 78256

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

PIMCO
840 NEWPORT CENTER DRIVE
SUITE 100
NEWPORT BEACH, CA 92660

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

AMERICAN FUNDS
333 SOUTH HOPE STREET
LOS ANGELES, CA 90071-1406

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

CALVERT RESEARCH AND MANAGEMENT
1825 CONNECTICUT AVENUE NW
SUITE 400
WASHINGTON, DC 20009

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

EQUITABLE FINANCIAL LIFE INSURANCE

13-5570651

(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

(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

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)

MUTUAL OF AMERICA INVESTMENT CORP

320 PARK AVENUE
NEW YORK, NY 10022

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) 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) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 12 15 37 65 | INSURANCE CARRIER | 975 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

EQUITABLE FINANCIAL LIFE INSURANCE

13-5570651

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) 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) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 37 | RECORDKEEPER | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 100 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) 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) 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 (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 (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 (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)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

For calendar plan year 2023 or fiscal plan year beginning 07/01/2023 and ending 06/30/2024

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------|
| A Name of plan <u>403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS</u> | B Three-digit plan number (PN) ▶ | <u>001</u> |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------|

| | |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>EASTERN PANHANDLE MENTAL HEALT</u> | D Employer Identification Number (EIN) <u>23-7116164</u> |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|

| | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I | Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs) |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT NUMBER SA2

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA

| | | |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| c EIN-PN <u>13-1614399-001</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>4296286</u> |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|

a Name of MTIA, CCT, PSA, or 103-12 IE: POOLED SEPARATE ACCOUNT 48

b Name of sponsor of entity listed in (a): EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

| | | |
|---------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------|
| c EIN-PN <u>13-5570651-000</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>537195</u> |
|---------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------|

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

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

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

| | | |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| c EIN-PN | d Entity code | e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e 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):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Financial Information 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). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan 403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS | B Three-digit plan number (PN) ▶ | 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500 EASTERN PANHANDLE MENTAL HEALT | D Employer Identification Number (EIN) 23-7116164 | |

Part I Asset and Liability Statement

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.

| | | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| Assets | | | |
| a Total noninterest-bearing cash | 1a | | |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 0 | 0 |
| (2) Participant contributions | 1b(2) | 0 | 0 |
| (3) Other | 1b(3) | | |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 0 | 0 |
| (2) U.S. Government securities | 1c(2) | 0 | 0 |
| (3) Corporate debt instruments (other than employer securities): | | | |
| (A) Preferred | 1c(3)(A) | 0 | 0 |
| (B) All other | 1c(3)(B) | 0 | 0 |
| (4) Corporate stocks (other than employer securities): | | | |
| (A) Preferred | 1c(4)(A) | 0 | 0 |
| (B) Common | 1c(4)(B) | 0 | 0 |
| (5) Partnership/joint venture interests | 1c(5) | 0 | 0 |
| (6) Real estate (other than employer real property) | 1c(6) | 0 | 0 |
| (7) Loans (other than to participants) | 1c(7) | 0 | 0 |
| (8) Participant loans | 1c(8) | 0 | 0 |
| (9) Value of interest in common/collective trusts | 1c(9) | 0 | 0 |
| (10) Value of interest in pooled separate accounts | 1c(10) | 0 | 0 |
| (11) Value of interest in master trust investment accounts | 1c(11) | 0 | 0 |
| (12) Value of interest in 103-12 investment entities | 1c(12) | 0 | 0 |
| (13) Value of interest in registered investment companies (e.g., mutual funds) | 1c(13) | 4280301 | 4833483 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | 897875 | 852336 |
| (15) Other | 1c(15) | 0 | 0 |

| 1d Employer-related investments: | | (a) Beginning of Year | (b) End of Year |
|--------------------------------------------------------------------|-------|-----------------------|-----------------|
| (1) Employer securities | 1d(1) | | |
| (2) Employer real property | 1d(2) | | |
| e Buildings and other property used in plan operation | 1e | | |
| f Total assets (add all amounts in lines 1a through 1e) | 1f | 5178176 | 5685819 |
| Liabilities | | | |
| g Benefit claims payable | 1g | 0 | 0 |
| h Operating payables | 1h | | |
| i Acquisition indebtedness | 1i | | |
| j Other liabilities | 1j | | |
| k Total liabilities (add all amounts in lines 1g through 1j) | 1k | 0 | 0 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f) | 1l | 5178176 | 5685819 |

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.

| Income | | (a) Amount | (b) Total |
|-----------------------------------------------------------------------------------------------|----------|------------|-----------|
| a Contributions: | | | |
| (1) Received or receivable in cash from: (A) Employers | 2a(1)(A) | 182166 | |
| (B) Participants | 2a(1)(B) | 251544 | |
| (C) Others (including rollovers) | 2a(1)(C) | 0 | |
| (2) Noncash contributions | 2a(2) | 0 | |
| (3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2) | 2a(3) | | 433710 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit) | 2b(1)(A) | 0 | |
| (B) U.S. Government securities | 2b(1)(B) | 0 | |
| (C) Corporate debt instruments | 2b(1)(C) | 0 | |
| (D) Loans (other than to participants) | 2b(1)(D) | 0 | |
| (E) Participant loans | 2b(1)(E) | 0 | |
| (F) Other | 2b(1)(F) | 22693 | |
| (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | | 22693 |
| (2) Dividends: (A) Preferred stock | 2b(2)(A) | 0 | |
| (B) Common stock | 2b(2)(B) | 0 | |
| (C) Registered investment company shares (e.g. mutual funds) | 2b(2)(C) | 0 | |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C) | 2b(2)(D) | | 0 |
| (3) Rents | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: (A) Aggregate proceeds | 2b(4)(A) | 0 | |
| (B) Aggregate carrying amount (see instructions) | 2b(4)(B) | 0 | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: (A) Real estate | 2b(5)(A) | | |
| (B) Other | 2b(5)(B) | 0 | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | | |

| | | (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) | | 584164 |
| (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) | | 95012 |
| c Other income..... | 2c | | 0 |
| d Total income. Add all income amounts in column (b) and enter total..... | 2d | | 1135579 |

Expenses

| | | | |
|--------------------------------------------------------------------------------------------|---------------|--------|--------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers..... | 2e(1) | 626746 | |
| (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) | | 626746 |
| f Corrective distributions (see instructions)..... | 2f | | |
| g Certain deemed distributions of participant loans (see instructions)..... | 2g | | |
| h Interest expense..... | 2h | | |
| i Administrative expenses: | | | |
| (1) Salaries and allowances..... | 2i(1) | | |
| (2) Contract administrator fees..... | 2i(2) | 60 | |
| (3) Recordkeeping fees..... | 2i(3) | 1030 | |
| (4) IQPA audit fees..... | 2i(4) | | |
| (5) Investment advisory and investment management fees..... | 2i(5) | 100 | |
| (6) Bank or trust company trustee/custodial fees..... | 2i(6) | 0 | |
| (7) Actuarial fees..... | 2i(7) | | |
| (8) Legal fees..... | 2i(8) | | |
| (9) Valuation/appraisal fees..... | 2i(9) | | |
| (10) Other trustee fees and expenses..... | 2i(10) | | |
| (11) Other expenses..... | 2i(11) | | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 1190 |
| j Total expenses. Add all expense amounts in column (b) and enter total..... | 2j | | 627936 |

Net Income and Reconciliation

| | | | |
|-------------------------------------------------------------------------------|--------------|--|--------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 507643 |
| 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: **BROWN, EDWARDS AND COMPANY, LLP**

(2) EIN: **55-0504608**

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 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) | | X | |
| 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.) | | X | |
| c 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.) | | X | |
| d 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.) | | X | |
| e Was this plan covered by a fidelity bond? | X | | 500000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | X | |
| g 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? | | X | |
| h 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? | | X | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | X | | |
| j 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.) | | X | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | | X | |
| l Has the plan failed to provide any benefit when due under the plan? | | X | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | X | |
| n 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. | | | |

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.)

| 5b(1) Name of plan(s) | 5b(2) EIN(s) | 5b(3) 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 _____.

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|

For calendar plan year 2023 or fiscal plan year beginning 07/01/2023 and ending 06/30/2024

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| A Name of plan <u>403(B) THRIFT PLAN FOR EMPLOYEES OF EASTERN PANHANDLE MENTAL HEALTH CENTER, INC. DBA EASTRIDGE HEALTH SYSTEMS</u> | B Three-digit plan number (PN) ▶ | <u>001</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>EASTERN PANHANDLE MENTAL HEALT</u> | D Employer Identification Number (EIN) <u>23-7116164</u> | |

| | |
|---------------|----------------------|
| Part I | Distributions |
|---------------|----------------------|

All references to distributions relate only to payments of benefits during the plan year.

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| 1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions..... | 1 | <u>0</u> |
| 2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>13-3590259</u> | | |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3. | | |
| 3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year | 3 | |

| | |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.) |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| 4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8. | | | |
| 5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____ If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. | | | |
| 6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) | 6a | | |
| b Enter the amount contributed by the employer to the plan for this plan year | 6b | | |
| c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) | 6c | | |
| If you completed line 6c, skip lines 8 and 9. | | | |
| 7 Will the minimum funding amount reported on line 6c be met by the funding deadline? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

| | |
|-----------------|-------------------|
| Part III | Amendments |
|-----------------|-------------------|

| | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| 9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

| | |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Part IV | ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11 a Does the ESOP hold any preferred stock? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12 Does the ESOP hold any stock that is not readily tradable on an established securities market? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment) | 14a | |
| b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment) | 14b | |
| c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)..... | 14c | |

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

| | | |
|-------------------------------------------------------------------------------------------------------|------------|--|
| a The corresponding number for the plan year immediately preceding the current plan year | 15a | |
| b The corresponding number for the second preceding plan year | 15b | |

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| a Enter the number of employers who withdrew during the preceding plan year | 16a | |
| b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers | 16b | |

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment.....

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment.....

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
 Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%
 High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No


b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation.....

Part VII IRS Compliance Questions

21a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).
 Design-based safe harbor method
 "Prior year" ADP test
 "Current year" ADP test
 N/A

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/____ (MM/DD/YYYY) and the Opinion Letter serial number _____.



**403(b) Thrift Plan for Employees of
Eastern Panhandle Mental Health
Center, Inc.**

DBA Eastridge Health Systems

Financial Report

June 30, 2024

403(b) Thrift Plan for Employees of
Eastern Panhandle Mental Health Center, Inc.
DBA Eastridge Health Systems

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Independent Auditor's Report

To the Plan Administrator
403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc.
DBA Eastridge Health Systems
Martinsburg, West Virginia

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

We have performed audits of the accompanying financial statements of 403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems (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 June 30, 2024 and 2023, and the related statement of changes in net assets available for benefits for the year ended June 30, 2024, 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 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 qualified institutions as of June 30, 2024 and 2023 and for the year ended June 30, 2024, stating that the certified investment information, as described in Note 3 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 Auditor's Responsibilities for the Audit of the Financial Statements section:

- the amounts and disclosures in the financial statements referred to above, 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 financial statements referred to above related to assets held by and certified to by qualified institutions agrees to, or is derived from, in all material respects, the



information prepared and certified by institutions that management determined meet 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. Our responsibilities under those standards are further described in the Auditor's 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 the financial statements are available to be 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.

Auditor's 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 auditor's 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 generally accepted auditing standards 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 generally accepted auditing standards, 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 certifications, 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 Matter - Supplemental Schedules Required by ERISA

The supplemental Schedule H, Line 4i – Schedule of Assets (Held at End of Year) as of June 30, 2024 is presented for purposes of additional analysis and is 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 schedule, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audit 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 generally accepted auditing standards. For information included in the supplemental schedule 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 schedule, we evaluated whether the supplemental schedule, other than the information agreed to or derived from the certified investment information, including its form and content, is 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 schedule, other than the information in the supplemental schedule 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 schedule 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).

Brown, Edwards & Company, L.L.P.

CERTIFIED PUBLIC ACCOUNTANTS

Charleston, West Virginia
April 7, 2025



Financial Statements



**403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc.
DBA Eastridge Health Systems**

**Statements of Net Assets Available for Benefits
June 30, 2024 and 2023**

| | 2024 | 2023 |
|----------------------------------------------|-------------------------|-------------------------|
| ASSETS | | |
| Investments at fair value: | | |
| Pooled separate accounts | \$ 4,833,483 | \$ 4,280,301 |
| General account | 433,891 | 464,350 |
| | 5,267,374 | 4,744,651 |
| Investments at contract value | 418,445 | 433,525 |
| Receivables: | | |
| Employee contribution | 9,402 | 9,608 |
| Employer contribution | 7,398 | 7,106 |
| | 16,800 | 16,714 |
| NET ASSETS AVAILABLE FOR BENEFITS | \$ 5,702,619 | \$ 5,194,890 |

The Notes to Financial Statements are an integral part of these statements.

**403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc.
DBA Eastridge Health Systems**

**Statement of Changes in Net Assets Available for Benefits
Year Ended June 30, 2024**

ADDITIONS TO NET ASSETS ATTRIBUTED TO:

Investment income:

| | |
|-----------------------------------------------|----------------|
| Net appreciation in fair value of investments | \$ 679,176 |
| Dividends and interest | 22,693 |
| | <u>701,869</u> |

Contributions:

| | |
|-------------|----------------|
| Employer | 179,956 |
| Participant | 253,840 |
| | <u>433,796</u> |

Total additions 1,135,665

DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:

| | |
|-------------------------------|----------------|
| Benefits paid to participants | 626,348 |
| Administrative expenses | 1,588 |
| | <u>627,936</u> |

Total deductions 627,936

Net increase in net assets available for benefits 507,729

Net assets available for benefits, beginning of year 5,194,890

Net assets available for benefits, end of year \$ 5,702,619

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Note 1 – Plan Description

The following description of 403(b) Thrift Plan of Eastern Panhandle Mental Health Center Inc. DBA Eastridge Health Systems (the “Plan”) provides only general information. Participants should refer to the plan document for a more complete description of the Plan’s provisions.

General

The Plan, originally effective July 1, 1997, and restated July 1, 2019, is a defined contribution plan covering all employees of Eastern Panhandle Mental Health Center Inc. DBA Eastridge Health Systems (the “Company”). Participants are immediately eligible to make contributions into the Plan. Participants are eligible to receive employer contributions after completing one year of service and attaining the age of 21. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”).

Contributions

Participants may elect to contribute up to 100 percent of annual compensation in pre-tax or Roth contributions, as defined in the plan document and allowed by law. The Plan permits catch-up contributions for participants who have attained age 50 by the end of the plan year. Participants may also rollover eligible amounts from other qualified plans. Employer contributions are discretionary.

Participant Accounts

Each participant’s account is credited with the participant’s contribution, the Company’s contribution, if applicable, and the Plan’s earnings and losses. The benefit to which a participant is entitled is the benefit that can be provided from the participant’s vested account. Participants direct the investment of their accounts into various investment options offered by the Plan.

Investment Options

Each plan participant has the right to direct all employee deferrals and employer contributions and earnings of their account among the various accounts provided under the Plan. Participants may transfer funds between investment options at any time. Participants should refer to the most recent annual report of each investment option for information on risk factors, asset concentrations, use of derivative financial instruments and other financial data.

Vesting

Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in the employer contribution portion of their accounts plus actual earnings thereon is based on years of credited service as follows:

| <u>Credited Services</u> | <u>Percent Vested</u> |
|--------------------------|-----------------------|
| 2 years | 20% |
| 3 years | 50% |
| 4 years | 75% |
| 5 years | 100% |

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Payment of Benefits

Upon termination of employment due to termination of service, death, disability, or retirement, participants may elect to receive the value of their vested account balance in a lump-sum distribution, or various forms of annuities provided in the plan document. In-service withdrawal options are available to participants under certain circumstances.

Loans to Participants

Participants may borrow the lesser of \$50,000 (reduced by the participant's highest outstanding loan balance during the 12-month period ending on the date of the loan) or 50 percent of their vested account balance. In addition, participants may only borrow one loan at a time. Loan terms range up to five years but may be extended if the proceeds are to be used for the purchase of a primary residence.

Loans are issued directly from Mutual of America Life Insurance Company and loan principal is not advanced from participant accounts. The loans are secured by the balance in the participant's account and bear interest at a rate of 5.85 percent. Principal and interest are paid ratably on a payment schedule established when the loan is originated. Scheduled payments are made no less frequently than quarterly. Participants make payments through payroll deductions. Based on the plan administrator's determination, a loan to a participant that is defaulted and remains in default will be offset through foreclosure on the plan assets held in the participant's account as collateral. Balances held in participant accounts that are held in reserve as loan collateral are restricted from withdrawal, transfer, or distributions.

A total of \$78,545 and \$79,325 in participant account balances were reserved as collateral for loans to participants at June 30, 2024 and 2023, respectively. During 2024, loan repayments to Mutual of America Life Insurance Company included \$3,965 in interest.

Forfeited Accounts

Forfeitures are used to reduce future employer contributions. At June 30, 2024 and 2023, there were no forfeited non-vested accounts. During 2024, \$12,008 of forfeited non-vested accounts were used to reduce employer contributions.

Note 2 – Summary of Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared under the accrual method of accounting.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosure. Accordingly, actual results may differ from those estimates.

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Investment Valuation and Income Recognition

Except as noted below, 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. See Note 4 for discussion of fair value measurements.

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

Investments in fully benefit-responsive investment contracts are reported at contract value. Contract value, also referred to as book value, is equal to total contribution allocated to the investment, less withdrawals and expenses, plus accrued interest.

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. 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.

Payment of Benefits

Benefits are recorded when paid.

Administrative Expenses

Certain administrative expenses incidental to the administration of the Plan, including fees of the administrative agent and independent public accountants, may be paid by the Plan. The Company, at its discretion, decided to pay for certain of these administrative expenses on behalf of the Plan. Most investment options have management fees, which reduce the overall return on assets. A portion of these fees and expenses were paid by the Company for the year ended June 30, 2024.

Subsequent Events

The Plan has evaluated the subsequent events through April 7, 2025, the date the financial statements were available to be issued.

Note 3 – Custodians' Certification

Certain information was certified as complete and accurate by Mutual of America Life Insurance Company and Equitable Financial Life Insurance Company, the Custodians of the Plan's assets. This information is as follows:

- Investment assets
- Investment transactions
- Investment income
- Schedule H, Line 4i – Schedule of Assets (Held at End of Year)

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Note 4 – Fair Value Measurements

The Plan’s pooled separate accounts are reported at fair value in the accompanying statements of net assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with those of other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The fair value measurement accounting literature establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level 1 inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority; Level 2 inputs consist of observable inputs other than quoted prices for identical assets; and Level 3 inputs are unobservable and have the lowest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. Level 3 inputs are used only when Level 1 or Level 2 inputs are not available.

Level 1 Fair Value Measurements

The fair values of pooled separate accounts are based on quoted net asset values of the shares held by the Plan at year end.

Level 2 Fair Value Measurements

The General Interest Account is carried at contract value, as computed by Equitable Financial Life Insurance Company, which equals contributions and transfers in, plus interest, minus withdrawals and transfers out, and annual and withdrawal fees specified in the contract. Contract value, which is deemed to approximate fair value, since participants may generally transact at contract value.

The following tables set forth, by level within the fair value hierarchy, the Plan’s investments at fair value as of June 30, 2024 and 2023:

| | Fair Value | Level 1 | Level 2 |
|---------------------------------|--------------|--------------|------------|
| <u>June 30, 2024</u> | | | |
| Pooled separate accounts | \$ 4,833,483 | \$ 4,833,483 | \$ - |
| General account | 433,891 | - | 433,891 |
| Total | 5,267,374 | \$ 4,833,483 | \$ 433,891 |
| <u>June 30, 2023</u> | | | |
| Pooled separate accounts | \$ 4,280,301 | \$ 4,280,301 | \$ - |
| General account | 464,350 | - | 464,350 |
| Total | \$ 4,744,651 | \$ 4,280,301 | \$ 464,350 |

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Note 5 – Investment Contracts

In December 2017, the Plan entered into a fully benefit-responsive investment contract with Mutual of America Life Insurance Company. Mutual of America Life Insurance Company maintains the contributions in a general account. The general account was credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

Because the investment contract is fully benefit-responsive, contract value is the relevant measurement attribute for that portion of net assets available for benefits attributable to the investment contract. Contract value, as reported to the Plan by Mutual of America Life Insurance Company, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may direct the withdrawal or transfer of all or a portion of their investment at contract value. There are no reserves against contract value for credit risk of the contract issuer or otherwise. The interest rate is adjusted by the insurer periodically based on market conditions.

Certain events limit the ability of the Plan to transact at contract value with the issuer. Such events include the following: (1) amendments to the plan documents (including complete or partial plan termination or merger with another plan), (2) changes to Plan's prohibition on competing investment options or deletion of equity wash provisions, (3) bankruptcy of the plan sponsor or other plan sponsor events that cause a significant withdrawal from the Plan, or (4) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The plan administrator does not believe that the occurrence of any such value event, which would limit the Plan's ability to transact at contract value with participants, is probable.

The contract is subject to certain termination clauses. The Plan may transfer funds and terminate the contract; however, the issuer reserves the right to defer such payment for up to 6 months following the contract's termination date. Alternatively, the Plan may leave the funds in the investment contract until such time as all participants have elected to withdraw their investment.

Note 6 – Tax Status

The Plan is designed in accordance with applicable sections of the IRC. The Plan Administrator believes that the Plan is currently being operated in compliance with the applicable requirements of the IRC.

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 tax position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan Administrator has analyzed the tax positions taken by the Plan and has concluded that as of June 30, 2024 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.

403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

Notes to Financial Statements

June 30, 2024

Note 7 – Related Parties and Party-In-Interest Transactions

Certain administrative functions are performed by officers or employees of the Company. These employees are also Plan participants. No such officer or employee received compensation from the Plan.

Fees paid by the Plan to the Custodian for investment management services are considered to be related party transactions and amounted to \$1,588 for the year ended June 30, 2024.

Note 8 – Plan Termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants will be 100% vested in their accounts.

Note 9 – Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at June 30, 2024 and 2023, to Form 5500:

| | <u>2024</u> | <u>2023</u> |
|----------------------------------------------------------------|---------------------|---------------------|
| Net assets available for benefits per the financial statements | \$ 5,702,619 | \$ 5,194,890 |
| Employee contributions receivable | (9,402) | (9,608) |
| Employer contributions receivable | (7,398) | (7,106) |
| Net assets available for benefits per Form 5500 | <u>\$ 5,685,819</u> | <u>\$ 5,178,176</u> |

The following is a reconciliation of the increase in net assets available for benefits per the financial statements for the year ended June 30, 2024 to Form 5500:

| | |
|----------------------------------------------------------------------------|-------------------|
| Increase in net assets available for benefits per the financial statements | \$ 507,729 |
| Less: Employee and employer contributions receivable at June 30, 2024 | (16,800) |
| Add: Employee and employer contributions receivable at June 30, 2023 | 16,714 |
| Increase in net assets available for benefits per Form 5500 | <u>\$ 507,643</u> |



Supplemental Schedule

**403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc.
DBA Eastridge Health Systems**

**Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
EIN 23-7116164/Plan #001
June 30, 2024**

| (a) | (b) Identity of Issuer, Borrower, Lessor, or Similar Party | (c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|-----|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------|----------------------|
| | General account: | | | |
| * | AXA Equitable Life Insurance Company | General Interest Account | ** | \$ 433,891 |
| | Fully Benefit-Responsive Investment Contract: | | | |
| * | Mutual of America Life Insurance Company | Mutual of America Interest Accumulation Account | ** | 418,445 |
| | Pooled Separate Accounts: | | | |
| * | Mutual of America Life Insurance Company | Mutual of America Aggressive Allocation | ** | 143,893 |
| * | Mutual of America Life Insurance Company | Mutual of America Conservative Allocation | ** | 583,181 |
| * | Mutual of America Life Insurance Company | Mutual of America Moderate Allocation | ** | 287,536 |
| * | Mutual of America Life Insurance Company | T. Rowe Price Blue Chip Growth Fund | ** | 46,292 |
| * | Mutual of America Life Insurance Company | Mutual of America Balanced Fund | ** | 2,679 |
| * | Mutual of America Life Insurance Company | Mutual of America Equity Index | ** | 1,374,558 |
| * | Mutual of America Life Insurance Company | Mutual of America Mid-Cap Equity Index | ** | 7,988 |
| * | Mutual of America Life Insurance Company | Mutual of America 2020 Retirement | ** | 2,727 |
| * | Mutual of America Life Insurance Company | Mutual of America 2025 Retirement | ** | 268,119 |
| * | Mutual of America Life Insurance Company | Mutual of America 2030 Retirement | ** | 189,856 |
| * | Mutual of America Life Insurance Company | Mutual of America 2035 Retirement | ** | 853,589 |
| * | Mutual of America Life Insurance Company | Mutual of America 2040 Retirement | ** | 98,429 |
| * | Mutual of America Life Insurance Company | Mutual of America 2045 Retirement | ** | 99,786 |
| * | Mutual of America Life Insurance Company | Mutual of America 2050 Retirement | ** | 26,542 |
| * | Mutual of America Life Insurance Company | Mutual of America 2055 Retirement | ** | 95,139 |
| * | Mutual of America Life Insurance Company | Mutual of America 2060 Retirement | ** | 32,185 |
| * | Mutual of America Life Insurance Company | Mutual of America 2065 Retirement | ** | 19,247 |
| * | Mutual of America Life Insurance Company | Mutual of America Retirement Income | ** | 4,399 |
| * | Mutual of America Life Insurance Company | Vanguard VIF REIT Index Portfolio | ** | 28,637 |
| * | Mutual of America Life Insurance Company | PIMCO VT Real Return Institutional Portfolio | ** | 48,781 |
| * | Mutual of America Life Insurance Company | Victory RS Small Cap Growth Equity VIP Series | ** | 24,278 |
| * | Mutual of America Life Insurance Company | Mutual of America Small Cap Equity Index | ** | 28,381 |
| * | Mutual of America Life Insurance Company | Mutual of America Small-Cap Growth | ** | 29,082 |
| * | Mutual of America Life Insurance Company | American Century VP Cap Apprec | ** | 883 |
| * | Mutual of America Life Insurance Company | Fidelity VIP Equity-Income Portfolio | ** | 23 |
| * | Mutual of America Life Insurance Company | Mutual of America All America Fund | ** | 34 |
| * | Mutual of America Life Insurance Company | Vanguard VIF Diversified Value | ** | 11 |
| * | Mutual of America Life Insurance Company | MFS VIT III Mid Cap Value | ** | 11 |
| * | Mutual of America Life Insurance Company | Mutual of America Mid Cap Value | ** | 11 |
| * | Mutual of America Life Insurance Company | Goldman Sachs VIT Small Cap Equity Insights | ** | 11 |
| * | Equitable Financial Life Insurance Company | Multimanager Aggressive Equity | ** | 148,841 |
| * | Equitable Financial Life Insurance Company | EQ/Common Stock Index | ** | 180,778 |
| * | Equitable Financial Life Insurance Company | EQ/International Equity Index | ** | 5,077 |
| * | Equitable Financial Life Insurance Company | EQ/Large Cap Value Managed Vol | ** | 38,196 |
| * | Equitable Financial Life Insurance Company | EQ/Mid Cap Value Managed Vol | ** | 4,509 |
| * | Equitable Financial Life Insurance Company | EQ/AB Small Cap Growth | ** | 93,280 |
| * | Equitable Financial Life Insurance Company | EQ/JP Morgan Valuation Opportunities | ** | 357 |
| * | Equitable Financial Life Insurance Company | EQ/Core Plus Bond | ** | 1,075 |
| * | Equitable Financial Life Insurance Company | EQ/Intermediate Government Bond | ** | 115 |
| * | Equitable Financial Life Insurance Company | EQ/Moderate Allocation | ** | 98 |
| * | Equitable Financial Life Insurance Company | EQ/Capital Group Research | ** | 2,871 |
| * | Equitable Financial Life Insurance Company | EQ/T. Rowe Price Growth Stock | ** | 11,533 |
| * | Equitable Financial Life Insurance Company | EQ/Morgan Stanley Mid Cap Growth | ** | 6,883 |
| * | Equitable Financial Life Insurance Company | EQ/Gamco Small Company Value | ** | 7,259 |
| * | Equitable Financial Life Insurance Company | EQ/Quality Bond PLUS | ** | 3,393 |
| * | Equitable Financial Life Insurance Company | EQ/Fidelity Institutional AM Large Cap | ** | 10,062 |
| * | Equitable Financial Life Insurance Company | EQ/Intermediate Valuation Managed Vol | ** | 15 |
| * | Equitable Financial Life Insurance Company | EQ/Blackrock Basic Value Equity | ** | 283 |
| * | Equitable Financial Life Insurance Company | EQ/Large Cap Growth Index | ** | 158 |
| * | Equitable Financial Life Insurance Company | Multimanager Technology | ** | 192 |
| * | Equitable Financial Life Insurance Company | EQ/Money Market | ** | 186 |
| * | Equitable Financial Life Insurance Company | EQ/Mid Cap Index | ** | 36 |
| * | Equitable Financial Life Insurance Company | Multimanager Core Bond | ** | 12 |
| * | Equitable Financial Life Insurance Company | EQ/Core Bond Index | ** | 28 |
| * | Equitable Financial Life Insurance Company | EQ/American Century Mid Cap Val | ** | 608 |
| * | Equitable Financial Life Insurance Company | EQ/Horizon Small Cap Value | ** | 242 |
| * | Equitable Financial Life Insurance Company | EQ/Large Cap Growth Managed Vol | ** | 23 |
| * | Equitable Financial Life Insurance Company | EQ/Loomis Sayles Growth | ** | 1,204 |
| * | Equitable Financial Life Insurance Company | EQ/Global Equity Managed Vol | ** | 1,032 |
| * | Equitable Financial Life Insurance Company | EQ/Calvert Socially Responsible | ** | 17,760 |
| * | Equitable Financial Life Insurance Company | EQ/Conservative Plus Allocation | ** | 170 |
| * | Equitable Financial Life Insurance Company | EQ/Moderate Plus Allocation | ** | 638 |
| * | Equitable Financial Life Insurance Company | Target 2045 Allocation | ** | 97 |
| * | Equitable Financial Life Insurance Company | EQ/Conservative Allocation | ** | 100 |
| * | Equitable Financial Life Insurance Company | EQ/PIMCO Ultra Short Bond | ** | 38 |
| * | Equitable Financial Life Insurance Company | EQ/Small Company Index | ** | 19 |
| * | Equitable Financial Life Insurance Company | EQ/Boston Advisors Equity Income | ** | 27 |
| | | Total pooled separate accounts | | <u>4,833,483</u> |
| | | | | <u>\$ 5,685,819</u> |

* Party-in-interest

** Cost omitted for participant directed investments.

Attachment to July 2023 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name 403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, Inc. DBA Eastridge Health Systems

EIN: 23-7116164
PN: 001

| (a) | (b) identity of issuer, borrower, lessor, or similar party | (c) Description of investment including maturity date, rate of interest, collateral par, or maturity value. | (d) Cost | (e) Current value |
|-----|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------|-------------------|
| * | Mutual of America | GROUP ANNUITY CONTRACT Fidelity VIP Equity-Income Portfolio | | 23 |
| * | Mutual of America | GROUP ANNUITY CONTRACT Goldman Sachs VIT Small Cap Equity Insights Fund | | 11 |
| * | Mutual of America | GROUP ANNUITY CONTRACT LVIP American Century Capital Appreciation Fund | | 883 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MFS VIT III Mid Cap Value Portfolio | | 11 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Aggressive Allocation Fund | | 143,893 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA All America Fund | | 34 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Balanced Fund | | 2,679 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2020 Fund | | 2,727 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2025 Fund | | 268,119 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2030 Fund | | 189,856 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2035 Fund | | 853,589 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2040 Fund | | 98,429 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2045 Fund | | 99,786 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2050 Fund | | 26,542 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2055 Fund | | 95,139 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2060 Fund | | 32,185 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Clear Passage 2065 Fund | | 19,247 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Conservative Allocation Fund | | 583,181 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Equity Index Fund | | 1,374,556 |

Attachment to July 2023 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name 403(b) Thrift Plan for Employees of Eastern Panhandle Mental Health Center, **EIN:** 23-7116164
Inc. DBA Eastridge Health Systems **PN:** 001

| (a) | (b) identity of issuer, borrower, lessor, or similar party | (c) Description of investment including maturity date, rate of interest, collateral par, or maturity value. | (d) Cost | (e) Current value |
|-----|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------|-------------------|
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Mid Cap Equity Index Fund | | 7,988 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Mid Cap Value Fund | | 11 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Moderate Allocation Fund | | 287,536 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Retirement Income Fund | | 4,399 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Small Cap Equity Index Fund | | 28,381 |
| * | Mutual of America | GROUP ANNUITY CONTRACT MoA Small Cap Growth Fund | | 29,082 |
| * | Mutual of America | GROUP ANNUITY CONTRACT Mutual of America Interest Accumulation Account | | 418,510 |
| * | Mutual of America | GROUP ANNUITY CONTRACT PIMCO VIT Real Return Portfolio | | 48,781 |
| * | Mutual of America | GROUP ANNUITY CONTRACT T. Rowe Price Blue Chip Growth Portfolio | | 46,292 |
| * | Mutual of America | GROUP ANNUITY CONTRACT Vanguard VIF Diversified Value Portfolio | | 11 |
| * | Mutual of America | GROUP ANNUITY CONTRACT Vanguard VIF Real Estate Index Portfolio | | 28,637 |
| * | Mutual of America | GROUP ANNUITY CONTRACT Victory RS Small Cap Growth Equity VIP Series | | 24,278 |