

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, a single-employer plan, a DFE, 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: 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 SHARED SERVICES HEALTH PLAN, 1b Three-digit plan number (PN) 501, 1c Effective date of plan 11/01/2008, 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) SHARED SERVICES CONSORTIUM, LLC C/O BENECON 201 E. OREGON ROAD SUITE 100 LITITZ, PA 17543, 2b Employer Identification Number (EIN) 25-1882792, 2c Plan Sponsor's telephone number 717-723-4600, 2d Business code (see instructions) 541990

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.

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	2811
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ..... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	2680
	<b>6a(2)</b>	2730
	<b>6b</b>	124
	<b>6c</b>	
	<b>6d</b>	2854
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	

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

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
4A 4E

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(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 checked="" type="checkbox"/> Trust	(3) <input checked="" 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)

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

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

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**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.

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**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 158882168

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**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**

<b>A</b> Name of plan <b>SHARED SERVICES HEALTH PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHARED SERVICES CONSORTIUM, LLC</b>		<b>D</b> Employer Identification Number (EIN) <b>25-1882792</b>	

**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  
**EVEREST REINSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>22-2005057</b>	<b>26921</b>	<b>SL3120001-201</b>	<b>2854</b>	<b>07/01/2023</b>	<b>06/30/2024</b>

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

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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**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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> 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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

<b>a</b> State the basis of premium rates ▶		
<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year.....	<b>6c</b>	
<b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... Specify nature of costs ▶	<b>6d</b>	
<b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
<b>f</b> 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)

<b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration                      (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment                      (4) <input type="checkbox"/> other ▶		
<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	<b>7e(5)</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	5112725
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A?.....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SHARED SERVICES HEALTH PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHARED SERVICES CONSORTIUM, LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>25-1882792</b>	

**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

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

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

HIGHMARK INC.

23-1294723

(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	NONE	688528	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

THE BENECON GROUP

23-1315351

(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?
13	NONE	621326	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GEISINGER INDEMNITY INSURANCE CO.

23-2815174

(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	NONE	119807	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)

HENDERSON BROTHERS

25-0543730

(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?
22	NONE	95119	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

UMR

39-1995276

(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	NONE	72672	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

UPMC

25-1844144

(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	NONE	60227	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)

TOMPKINS INSURANCE AGENCY

83-0389955

(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?
22	NONE	34320	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

INDEPENDENCE ADMINISTRATORS

23-2184623

(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	NONE	32724	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STRICKLER AGENCY, INC.

23-1605938

(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?
22	NONE	29198	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)

EMPIRX HEALTH

155 CHESTNUT RIDGE RD  
MONTVALE, NJ 07645

(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	NONE	24166	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

INNOVU

2403 SIDNEY ST SUITE 225  
PITTSBURGH, PA 15203

(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?
22	NONE	14824	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

TRUESCRIPTS

46-4334244

(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	NONE	14696	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)

SUSQUEHANNA INSURANCE

23-2838726

(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?
50	NONE	9590	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BSI CORPORATE BENEFITS LLC

51-0467698

(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?
22	NONE	8900	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(b) 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.

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

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

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

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

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

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

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

<b>Part III</b>	<b>Termination Information on Accountants and Enrolled Actuaries (see instructions)</b> (complete as many entries as needed)
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<b>a</b> Name: BAKER TILLY US, LLP	<b>b</b> EIN: 39-0859910
<b>c</b> Position: AUDITOR	
<b>d</b> Address: 740 W HAMILTON ST, SUITE 210 ALLENTOWN, PA 18101	<b>e</b> Telephone: 610-336-8180

Explanation: BAKER TILLY US, LLP COMPLETED A STRATEGIC INVESTMENT ON JUNE 3, 2024, AND AS A RESULT HAS APPLIED FOR AND OBTAINED A NEW EIN. THERE HAS BEEN NO CHANGE IN AUDIT FIRM.

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2023 or fiscal plan year beginning <b>07/01/2023</b> and ending <b>06/30/2024</b>	
<b>A</b> Name of plan <b>SHARED SERVICES HEALTH PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHARED SERVICES CONSORTIUM, LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>25-1882792</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**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
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>		
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	21486	0
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	1185432	2790755
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	19102291	14750190
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	20309209	17540945
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>	487573	1244391
<b>h</b> Operating payables .....	<b>1h</b>		
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>	1815987	462386
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	2303560	1706777
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	18005649	15834168

**Part II Income and Expense Statement**

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

<b>Income</b>		<b>(a)</b> Amount	<b>(b)</b> Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>	36721232	
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	9319573	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		46040805
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>	475328	
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		475328
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		
<b>(3)</b> Rents .....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts.....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts.....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities.....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<b>c</b> Other income .....	<b>2c</b>		10838523
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		57354656

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	46679837	
(2) To insurance carriers for the provision of benefits.....	<b>2e(2)</b>	11135092	
(3) Other.....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		57814929
<b>f</b> Corrective distributions (see instructions).....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	<b>2i(1)</b>		
(2) Contract administrator fees.....	<b>2i(2)</b>	1516257	
(3) Recordkeeping fees.....	<b>2i(3)</b>		
(4) IQPA audit fees.....	<b>2i(4)</b>		
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	185361	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>		
(7) Actuarial fees .....	<b>2i(7)</b>		
(8) Legal fees .....	<b>2i(8)</b>		
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	9590	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		1711208
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		59526137

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		-2171481
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**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: **BAKER TILLY US, LLP**

(2) EIN: **30-1413443**

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		17525000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

**5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

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

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

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

# **Shared Services Health Plan**

Financial Statements

June 30, 2024 and 2023

# Shared Services Health Plan

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June 30, 2024 and 2023

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## Independent Auditors' Report

To the Board of Trustees of  
Shared Services Health Plan

### Opinion

We have audited the financial statements of Shared Services Health Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits—modified cash basis as of June 30, 2024 and 2023, and the related statements of changes in net assets available for benefits—modified cash basis for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits—modified cash basis of the Plan as of June 30, 2024 and 2023, and the changes in its net assets available for benefits—modified cash basis for the years ended June 30, 2024 and 2023, in accordance with the modified cash basis of accounting described in Note 2.

### Basis for Opinion

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

### Emphasis of Matter - Basis of Accounting

We draw attention to Note 2 to the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

### Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the modified cash basis of accounting described in Note 2, and for determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible 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.

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.

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

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

In performing an audit in accordance with GAAS, we:

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

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.

*Baker Tilly US, LLP*

Allentown, Pennsylvania  
April 15, 2025

## Shared Services Health Plan

Statements of Net Assets Available for Benefits—Modified Cash Basis  
June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Assets</b>		
Investments:		
Money market accounts	\$ 13,969,436	\$ 18,209,025
Interest-bearing cash	780,754	893,266
	<u>14,750,190</u>	<u>19,102,291</u>
Total investments		
Receivables:		
Employer contributions	-	21,486
Excess loss insurance receivable	2,790,755	1,185,432
	<u>2,790,755</u>	<u>1,206,918</u>
Total receivables		
Total assets	<u>17,540,945</u>	<u>20,309,209</u>
<b>Liabilities</b>		
Deferred revenue	462,386	1,815,987
Due to insurance carriers	1,244,391	487,573
	<u>1,706,777</u>	<u>2,303,560</u>
Total liabilities		
Net assets available for benefits	<u>\$ 15,834,168</u>	<u>\$ 18,005,649</u>

See notes to financial statements

## Shared Services Health Plan

Statements of Changes in Net Assets Available for Benefits—Modified Cash Basis  
Years Ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Additions</b>		
Contributions:		
Employers	\$ 36,721,232	\$ 34,199,967
Employees	8,714,689	8,557,563
COBRA	147,527	211,994
Retirees	<u>457,357</u>	<u>248,562</u>
Total contributions	46,040,805	43,218,086
Excess loss insurance reimbursements	10,838,523	6,430,231
Interest income	<u>475,328</u>	<u>11,907</u>
Total additions	<u>57,354,656</u>	<u>49,660,224</u>
<b>Deductions</b>		
Claims expense	46,679,837	38,572,670
Excess loss insurance premiums paid	11,135,092	9,266,544
ASO fees	894,931	826,001
Plan management fees	621,326	578,832
Other administration expenses	<u>194,951</u>	<u>158,225</u>
Total deductions	<u>59,526,137</u>	<u>49,402,272</u>
Net (decrease) increase	(2,171,481)	257,952
<b>Net Assets Available for Benefits</b>		
Beginning of year	<u>18,005,649</u>	<u>17,747,697</u>
End of year	<u>\$ 15,834,168</u>	<u>\$ 18,005,649</u>

See notes to financial statements

# Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

## 1. Description of the Plan

The following description of the Shared Services Health Plan (the Plan) provides only general information. Participants should refer to the plan agreement applicable to the respective employer for more complete information.

### General

The sponsor of the Plan is Shared Services Consortium, LLC (SSC), a Pennsylvania limited liability company owned by the not-for-profit colleges and universities that participate in the Plan. SSC was established to provide savings opportunities for not-for-profit colleges and universities. This Plan is one means of achieving this mission. The Plan was established on November 1, 2008. Effective as follows, the Plan has provided health benefits to eligible employees, dependents, certain retirees and former employees electing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provisions of the following participating Pennsylvania not-for-profit colleges and universities (participating employers):

- Albright College - effective June 1, 2015
- Alvernia University - effective July 1, 2018
- Clarks Summit University - effective February 1, 2015; terminated June 30, 2024
- Elizabethtown College - effective January 1, 2012
- Franklin & Marshall College - effective November 1, 2008
- Juniata College - effective August 1, 2015
- La Roche University - effective December 1, 2020
- Pittsburgh Technical College - effective July 1, 2023; terminated June 30, 2024
- Rosemont College - effective November 1, 2008
- Susquehanna University - effective November 1, 2008
- Wilkes University - effective June 1, 2020
- Wilson College - effective July 1, 2019

The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

### Benefits

Benefits provided by the Plan vary based on the elections of each participating employer as follows:

#### Albright College

Health insurance and prescription drug benefits are provided to all regular, full-time employees working 30 hours per week and their dependents, in addition to, contracted faculty members on approved leave or approved for phased retirement with a reduced class load. Employees in full-time executive and faculty positions can enter the Plan the first day of the month following the first day that all eligibility requirements are met and, thereafter, at the annual open enrollment period. Administrative and support employees can enter the Plan the first day of the month following 45 days of employment and after all eligibility requirements are met and, thereafter, at the annual open enrollment period. A Preferred Provider Organization (PPO) Plan was offered through May 31, 2024. Effective June 1, 2024, two additional PPO Plans were offered.

## Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

### **Alvernia University**

Health insurance and prescription drug benefits are provided to all regular, full-time employees working 30 hours per week and their dependents. In most cases, employees can enter the Plan on the first day of the month coinciding with or following their date of hire and, thereafter, at the annual open enrollment period. Health plan options include two different PPO Plans, as well as a PPO Plan with a tiered network option.

### **Clarks Summit University**

Health insurance and prescription drug benefits are provided to all regular, full-time employees working an average of 30 hours per week and their dependents. Employees can enter the Plan on the first day of employment and, thereafter, at the annual open enrollment period. Health plan options include (1) a High Deductible PPO Plan option and (2) a High Deductible Custom PPO Plan option with a geographically restricted network.

### **Elizabethtown College**

Health insurance and prescription drug benefits are provided to all 52-week employees working 1,560 hours over 52 weeks and their dependents; and all 11-month employees working 1,625 hours over the academic year and their dependents; all 10-month employees working 1,787 hours over the academic year and their dependents; all 9-month employee working 1,462 hours over the academic year and their dependents. Also, retirees 60 years of age or more with at least 12 years of service and their dependents are covered. Upon reaching Medicare eligibility, Medicare will be primary payer and the group health plan will be secondary. The Plan includes a monthly surcharge for spouses. Employees can enter the Plan on the first day of employment and, thereafter, at the annual open enrollment period. Employees can choose between (1) the PPO Core \$1,000 option, (2) the PPO Tiered Network \$1,000 option, (3) a PPO Qualified High Deductible Health Plan (QHDHP) \$2,000 option, or (4) the PPO QHDHP Tiered Network \$2,000 Option.

### **Franklin & Marshall College**

Health insurance and prescription drug benefits are provided to all regular full-time employees authorized and scheduled to work at least 30 hours per week on an approved 9, 10, 11 or 12 months per year appointment. Paired faculty members on an approved joint appointment are eligible if working at least 1,040 hours annually. Centennial Conference employees and Lancaster City Alliance employees are eligible if they work on the Franklin & Marshall campus, are paid through the Franklin & Marshall payroll system, and are authorized and scheduled to work at least 30 hours per week on an approved 9, 10, 11 or 12 month per year appointment. Employees covered under a severance agreement are eligible for benefits. Retirees who retired prior to January 1, 2013 are eligible if they are 60 years of age or more with at least 10 consecutive years of full-time service with Franklin & Marshall College after age 50. Also, those covered under a Phased Retirement Program or Pre-Retirement Leave of Absence Agreement on or before December 31, 2012 and those covered under a Voluntary Early Retirement Program Agreement prior to January 1, 2013 are eligible for coverage. In addition, the spouse and dependent children of an eligible retiree are eligible for coverage. Upon reaching Medicare eligibility, Medicare will be primary payer and the group health plan through Franklin & Marshall College will be secondary for retirees and their spouse and/or dependent children. Employees are eligible on the date of hire. Health plan options include (1) a Tiered Network High Deductible Health Plan paired with an HRA (not available to retirees) and (2) a Tiered Network PPO Health Plan \$450 option. Effective July 1, 2024, a third option, the Tiered Network PPO QHDHP, was added.

## Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

### **Juniata College**

Health insurance and prescription drug benefits are provided to all regular, full-time employees who average 30 hours of service per week, including those with contracted employment break periods, or continued benefits under the terms of a severance agreement and their dependents. The Plan excludes spouses who decline group coverage from their employer. In most cases, employees can enter the Plan on the first day of the month following or coinciding with their date of hire and, thereafter, at the annual open enrollment period. Eligible retirees are those who are (1) age 55, (2) have a minimum of ten years employment and (3) were hired prior to January 1, 1997. The spouse and dependent children who are enrolled on the Plan at the time of retirement are eligible. A PPO plan and a QHDHP are offered.

### **La Roche University**

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least 30 hours per week and their eligible dependents. Employees can enter the Plan on the first day of the month coinciding with or following their date of hire and, thereafter, at the annual open enrollment period. Health Plan options include (1) a QHDHP PPO, (2) a QHDHP Exclusive Provider Organization (EPO), (3) a PPO and (4) and EPO.

### **Pittsburgh Technical College**

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least 30 hours per week and their eligible dependents. Employees can enter the Plan on the first day of the month following their date of hire and, thereafter, at the annual open enrollment period. Health Plan options include (1) a PPO CB Flex plan, and (2) a QHDHP PPO plan.

### **Rosemont College**

Health insurance and prescription drug benefits are provided to all regular, full-time and part-time employees who work at least 20 hours per week and their dependents. Ten-month employees are considered active, full-time employees throughout the two-month period that they are not on the regular payroll. Employees are eligible upon date of hire and begin coverage on the first day of the month following the date of hire. Health plan options include the (1) PPO 350 and (2) HDHP PPO paired with an HRA.

### **Susquehanna University**

Health insurance and prescription drug benefits are provided to regular full-time and benefits-eligible employees (appointed to a position that is to last for at least nine months and work a minimum of 21 hours per week during the academic year), and all faculty members who have received their tenured appointment regardless of the number of hours worked, and their dependents. Spouses are eligible for medical coverage only if the spouse is unemployed or the spouse is employed but is not eligible for medical coverage through the spouse's employer (or no coverage is available). In most cases, employees can enter the Plan on the first of the month following the first day that all eligibility requirements have been met and, thereafter, at the annual open enrollment period. Health plan options include (1) a PPO Blue option and (2) an HMO option.

### **Wilkes University**

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least 30 hours per week and their dependents. Employees are eligible upon date of hire and begin coverage on the first day of the month following or coinciding with the date of hire. Covered retirees include specific retirees listed in the summary plan description. When eligible for Medicare, Medicare will become primary payor and the Plan will reimburse as secondary. Spouses and dependent children of retirees are not eligible. Health plan options include the (1) PPO option and (2) QHDHP option.

## Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

### Wilson College

Health insurance and prescription drug benefits are provided to all regular, full-time employees working at least 30 hours per week and their dependents. The Plan includes a monthly surcharge for spouses and domestic partners who decline group coverage from their employer. Employees are eligible after they have been employed for 30 days and begin coverage on the first day of the month following or coinciding with the first day that eligibility requirements have been met. The waiting period is waived for former employees of Wilson College that are rehired within 13 months of their termination date. Health plan options include (1) a PPO Plan and (2) a QHDHP option.

The Plan also provides continuation of certain benefits upon termination of employment through COBRA as defined in the plan agreement applicable for the respective employer.

Health claims are processed through different insurance providers for each participating employer.

### Contributions

The contribution rates for each participating employer are determined at the beginning of each plan year based on actuarially determined claim projections and expected expenses for excess loss insurance premiums and administrative expenses. Contributions are calculated monthly based on the contribution rates and actual enrollment. Additional contributions may be required from participating employers based on actual results. Once all transactions for a policy year are settled, surplus amounts, if any, are determined for each participating employer. Surplus amounts from a finalized policy year can then be utilized by the participating employer to reduce the current policy period's required contributions. Participating employers utilized \$8,305,479 and \$6,780,317 in surplus for the years ended June 30, 2024 and 2023, respectively.

The Plan is contributory. As required, employees and retirees contribute a flat rate towards their coverage, which varies depending upon the level of coverage selected and, in some instances, based on the employee's annual base salary. The employee contribution requirement is determined by each participating employer and subject to periodic increases.

The costs of the postretirement benefit plan are shared by the Plan's participating employers who offer such benefits and their retirees.

### Risk Sharing

On March 10, 2005, SSC received permission from the Commonwealth of Pennsylvania Insurance Department to operate as exempt under Section 208 of the Insurance Department Act (Act of 1921, May 17 P.L. 789, as amended) and consequently established the Plan, which includes a risk-sharing provision between participating employers for which no certificate of authority from the Commonwealth of Pennsylvania Insurance Department has been obtained or is required to be obtained.

For each policy year, a portion of the participating employers' contributions is earmarked for the payment of claims versus other plan expenses and is referred to as the claim fund. At the end of the policy year, actual claims paid for each participating employer, net of specific excess loss insurance reimbursements, are compared to the respective contributions to determine a surplus or deficit. Each participating employer has pledged a certain percentage of a policy period's surplus to offset the deficit of other participating employers, should such a deficit arise.

During the year ended June 30, 2024, all participating employers ended the plan year with a surplus and no cross share was utilized. During the year ended June 30, 2023, all participating employers ended the plan year with a surplus and no cross share was utilized.

# Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

## Excess Loss Insurance

The Plan has acquired excess loss insurance through an insurer to cede the risk for individual claims exceeding a specified amount over the policy year. The specific excess loss insurance deductibles range from \$70,000 to \$100,000 for the years ended June 30, 2024 and 2023, respectively. The policy also contains an aggregate provision by which the Plan cedes all losses in participating employers' claim funds which remain after all agreed-upon specific excess loss insurance provisions and risk sharing pledges have been exhausted. All excess loss insurance reimbursements for the years ended June 30, 2024 and 2023 pertained to specific excess loss insurance provisions. Aggregate attachment points were not reached for any participating employer for the excess loss insurance periods ended June 30, 2024 and 2023.

## 2. Summary of Significant Accounting Policies

### Basis of Accounting

The Plan follows the practice of presenting its financial statements in accordance with the modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America (U.S. GAAP). Under the modified cash basis of accounting, only revenues collected, costs and expenses paid and assets and liabilities arising as a result of cash transactions occurring during the June 30, 2024 and 2023 plan years, as well as: (1) excess loss insurance reimbursements related to claims paid during the June 30, 2024 and 2023 plan years, (2) June income, expense and claim payments received or paid after the June 30, 2024 and 2023 plan year ends and (3) deferred revenue related to the prepayment of premiums for the June 30, 2025 and 2024 plan years, are recognized. In addition, receivables are written off when they are deemed to be uncollectible based upon review of the accounts by management, whereas U.S. GAAP requires that an allowance be used to recognize bad debts.

### Use of Estimates

The preparation of financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of incurred but not reported claims payable, contingent assets, liabilities and benefit obligations. Actual results could differ from these estimates.

### Benefit Obligations

In accordance with the modified cash basis of accounting, the effects of the liability for benefit obligations, including claims incurred, but not reported, and postretirement benefit obligations are not reflected in the Plan's financial statements as they would be following U.S. GAAP. Information on the Plan's benefit obligations are as follows:

### Claims Incurred, but not Reported

The Plan determines its expected benefit obligation for claims incurred, but not reported based on estimates of the ultimate liability for claims at the end of each accounting period. Such estimates consider loss development factors based on past claims experience for the participating employers as well as industry data. The Plan continually reviews methods for making such estimates. Due to the short-term nature of the obligation, time value of money was not used to discount future payments. Actual losses may vary from such estimates and variances could have a material effect on the disclosed obligation. However, plan management believes disclosed obligations are adequate.

## Shared Services Health Plan

Notes to Financial Statements  
June 30, 2024 and 2023

### Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to Franklin & Marshall, Elizabethtown and Juniata Colleges' employee service rendered to June 30, 2024 and 2023, respectively. Postretirement benefits include future benefits expected to be paid under the Plan to or for (a) currently retired employees and their beneficiaries and dependents and (b) active employees and their beneficiaries and dependents after retirement from service with the participating employer.

Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date. Albright College, Alvernia University, Clarks Summit University, LaRoche University, Pittsburgh Technical College, Rosemont College, Susquehanna University, Wilson College and Wilkes University do not provide any material postretirement benefits under this Plan.

The actuarial present value of the expected postretirement benefit obligation is determined by actuaries and is the amount that results from applying actuarial assumptions (as disclosed in the actuarial reports) to historical claims cost-data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements, such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment. The postretirement benefit obligation is unfunded and is paid with contributions received during the period in which the actual claims are incurred by the Plan.

The Plan's benefit obligations are as follows at June 30:

	<u>2024</u>	<u>2023</u>
Claims incurred, but not reported	\$ 4,060,000	\$ 3,620,000
Postretirement benefit obligations:		
Fully eligible active participants	610,000	658,000
Other active participants	46,000	45,000
Retirees and beneficiaries	<u>22,889,000</u>	<u>27,314,000</u>
	<u>23,545,000</u>	<u>28,017,000</u>
Total	<u>\$ 27,605,000</u>	<u>\$ 31,637,000</u>

### Interest-Bearing Cash

For the purpose of the Statements of Net Assets Available for Benefits—Modified Cash Basis, interest-bearing cash is defined as a demand deposit in a checking account at a financial institution.

### Investment Income Recognition

Interest income is recorded when received, in accordance with the modified cash basis of accounting.

## Shared Services Health Plan

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Notes to Financial Statements  
June 30, 2024 and 2023

### Payment of Benefits

Premiums paid by the Plan are recorded as excess loss insurance premiums paid in the accompanying Statements of Changes in Net Assets Available for Benefits—Modified Cash Basis.

Claims payments are recorded in accordance with the modified cash basis of accounting as described in Note 2. In July 2024 and 2023, claim payments of \$1,244,391 and \$487,573 were paid by the Plan to the insurance providers which related to the plan years July 1, 2023 to June 30, 2024 and July 1, 2022 to June 30, 2023, respectively. These amounts are recorded as a liability in the Statements of Net Assets Available for Benefits—Modified Cash Basis as of June 30, 2024 and 2023.

### Administrative and Other Expenses

Expenses are paid by the Plan and consist of Administrative Services Only (ASO) fees paid to various claims administrators, plan management fees paid to their third-party administrator and other administrative expenses.

### Excess Loss Insurance Receivables

Excess loss insurance receivables are expected reimbursements for claims paid by the Plan in excess of agreed-upon excess loss thresholds from the insurance carrier. The Plan continually reviews the excess loss insurance receivables to determine if any amounts are no longer deemed collectible. No bad debt expense was recorded for the years ended June 30, 2024 or 2023.

### Deferred Revenue

Deferred revenue represents administrative fees and claims fund deposits for July 2024 and 2023, received by the Plan from the participating employers during the years ended June 30, 2024 and 2023, respectively.

### Subsequent Events

Plan management has evaluated subsequent events through April 15, 2025. This date is the date the financial statements were available to be issued.

## 3. Concentrations of Credit Risk

Financial instruments that potentially subject the Plan to concentrations of credit risk consist principally of interest-bearing cash, money market accounts and excess loss insurance receivables. The Plan maintains its interest-bearing cash and money market accounts with one financial institution where the account balances generally exceed Federal Deposit Insurance Corporation insured limits. The Plan cedes portions of its claim risk exposure to one excess loss insurance carrier. Plan management monitors the financial condition of its banking and excess loss insurance carrier relationships.

## Shared Services Health Plan

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Notes to Financial Statements

June 30, 2024 and 2023

### 4. Tax Status

The Trust established under the Plan to hold the Plan's net assets is qualified pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the Trust's net interest income is exempt from income taxes. The Trust has obtained a favorable tax determination letter from the Internal Revenue Service (IRS) on May 7, 2011, in which the IRS stated that the Trust, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended and the Trust has added new members since receiving the determination letter. However, the plan administrator believes that the Trust is currently designed and being operated in compliance with the applicable requirements of the IRC. Plan management is required to evaluate tax positions taken by the Plan.

Plan management evaluated the Plan's tax positions and concluded that the Plan had maintained its tax exempt status and had taken no uncertain tax positions that require recognition or disclosure in the financial statements. Therefore, no provision or liability for income taxes has been included in the financial statements.

### 5. Plan Termination

Although it has not expressed any intention to do so, the plan sponsor and participating employers have the right under the Plan to modify the benefits provided to and contributions required of participants, to discontinue contributions at any time, and to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, the participating employers must pay the claims incurred and expenses of the Plan due up to the date of termination, plus extended benefits, if any, provided under the Plan.

### 6. Related-Party Transactions and Party in Interest Transactions

The Plan paid certain expenses related to plan operations and investment activity to various service providers. These transactions are party in interest transactions under ERISA. No officer or employee receives compensation from the Plan.

<b>Form 5500</b> <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	<b>Annual Return/Report of Employee Benefit Plan</b> 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). <b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b>	<small>OMB Nos. 1210 - 0110 1210 - 0089</small> <hr/> <b>2023</b> <hr/> <b>This Form is Open to Public Inspection</b>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2023 or fiscal plan year beginning <u>07/01/2023</u> and ending <u>06/30/2024</u>	
<b>A</b>	This return/report is for: <input type="checkbox"/> a multiemployer plan <input checked="" type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
<b>B</b>	This return/report is: <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
<b>C</b>	If the plan is a collectively-bargained plan, check here <input type="checkbox"/>
<b>D</b>	Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description) _____
<b>E</b>	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here <input type="checkbox"/>

<b>Part II</b>	<b>Basic Plan Information</b> - enter all requested information
<b>1a</b>	Name of plan <b>SHARED SERVICES HEALTH PLAN</b>
<b>1b</b>	Three-digit plan number (PN) ▶ <b>501</b>
<b>1c</b>	Effective date of plan <b>11/01/2008</b>
<b>2a</b>	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <b>SHARED SERVICES CONSORTIUM, LLC</b>  <b>C/O BENECON</b> <b>201 E. OREGON ROAD SUITE 100</b> <b>LITITZ PA 17543</b>
<b>2b</b>	Employer Identification Number (EIN) <b>25-1882792</b>
<b>2c</b>	Plan Sponsor's telephone number <b>717 723 4600</b>
<b>2d</b>	Business code (see instructions) <b>541990</b>

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

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

<b>SIGN HERE</b>		<b>4/14/25</b>	<b>JEFF SCACCIA</b>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 30px; width: 100%;"></div>
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<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
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<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	2,811
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<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).	
<b>a (1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b> 2,680
<b>a (2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b> 2,730
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b> 124
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c .....	<b>6d</b> 2,854
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>
<b>f</b> Total. Add lines 6d and 6e .....	<b>6f</b>
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>

<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	
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**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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

**4A** **4E**

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

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

<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)	<b>b General Schedules</b> (1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) - Number Attached <u>1</u> (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)
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**Multiple Employer Plan Participating Employer Information**  
**Shared Services Health Plan, EIN 25-1882792, PN 501**

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<b>(a) Name of Participating Employer</b>	<b>(b) EIN</b>	<b>(c) Percent of Total Contributions</b>
Albright College	23-1352615	9%
Alvernia University	23-1522643	8%
Clark Summit University	15-0543962	1%
Elizabethtown College	23-1352632	14%
Franklin & Marshall College	25-1352635	23%
Juniata College	23-1352652	10%
LaRoche University	25-1882792	4%
Pittsburgh Technical College	81-0903939	3%
Rosemont College	23-1365966	3%
Susquehanna University	23-1353385	11%
Wilkes University	24-0795506	11%
Wilson College	23-1352692	3%