

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

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 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE, etc.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report, etc.
C If the plan is a collectively-bargained plan, check here.
D Check box if filing under: Form 5558, automatic extension, special extension, the DFVC program, etc.
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: FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/1997
2a Plan sponsor's name (employer, if for a single-employer plan): FAITH REGIONAL HEALTH SERVICES
2b Employer Identification Number (EIN): 47-0796875
2c Plan Sponsor's telephone number: 402-644-7178
2d Business code (see instructions): 622000

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

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

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

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1332
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1332
	6a(2)	1337
	6b	0
	6c	0
	6d	1337
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	0

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 4B 4D 4E 4F 4G 4H 4L 4Q

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 FAITH REGIONAL HEALTH SERVICES		D Employer Identification Number (EIN) 47-0796875

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

METLIFE LEGAL PLANS

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
34-1650967	00000	6090470	117	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 2684	(b) Total amount of fees paid 374
--	--

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

GALLAGHER BENEFIT SERVICES, INC.

**PO BOX 95287
CHICAGO, IL 60694**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2684	0		3

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

GALLAGHER BENEFIT SERVICES, INC.

**181 EAST 5600 SOUTH, SUITE 240
SALT LAKE CITY, UT 84107**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	269	SUPPLEMENTAL COMPENSATION	3

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

GALLAGHER BENEFIT SERVICES, INC.

7101 SOUTH 82ND STREET
LINCOLN, NE 68516

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	106	NON-MONETARY COMPENSATION	3

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	

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) **▶ LEGAL**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	24642
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<p>A Name of plan FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 FAITH REGIONAL HEALTH SERVICES</p>	<p>D Employer Identification Number (EIN) 47-0796875</p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN HERITAGE LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-0781901	60534	G1955	450	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="color: blue;">81420</p>	<p>(b) Total amount of fees paid</p> <p style="color: blue;">0</p>
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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

GALLAGHER BENEFIT SERVICES, INC. 7441 O STREET, SUITE 102
LINCOLN, NE 68510

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
53730	0		3

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

TIM OLSON, INC. 16820 FRANCES STREET, SUTE 202
OMAHA, NE 68130

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
19859	0		3

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

HUB INTERNATIONAL GREAT PLAINS, LLC

11516 MIRACLE HILLS DRIVE, SUITE 10
OMAHA, NE 68154

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7831	0		3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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) ▶ **ACCIDENT, CRITICAL ILLNESS**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	245921
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

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. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 FAITH REGIONAL HEALTH SERVICES</p>	<p>D Employer Identification Number (EIN) 47-0796875</p>	

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
CURALINC, LLC, D.B.A. CURALINC HEALTHCARE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
33-1206383	00000	EAP	1385	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
---	--

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

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

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

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) ▶ **EMPLOYEE ASSISTANCE PROGRAM**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	26924
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

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. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 FAITH REGIONAL HEALTH SERVICES</p>	<p>D Employer Identification Number (EIN) 47-0796875</p>	

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
AMERITAS LIFE INSURANCE CORPORATION

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0098400	00000	010-301670	776	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 19228</p>	<p>(b) Total amount of fees paid 827</p>
---	--

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
GALLAGHER BENEFIT SERVICES, INC. 10050 REGENCY CIRCLE, SUITE 300 OMAHA, NE 68114

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
19228	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GALLAGHER BENEFIT SERVICES, INC. 2850 GOLF ROAD, 21ST FLOOR ROLLING MEADOWS, IL 60008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	827	FEES	3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	40911
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

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. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 FAITH REGIONAL HEALTH SERVICES</p>	<p>D Employer Identification Number (EIN) 47-0796875</p>	

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
UNITED OF OMAHA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0322111	69868	GLUG0C6SJ	1156	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 5945</p>	<p>(b) Total amount of fees paid 30039</p>
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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
FMLASOURCE, INC. **455 NORTH CITYFRONT PLAZA DRIVE**
CHICAGO, IL 60611

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	20965	ADMINISTRATION	5

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GALLAGHER BENEFIT SERVICES, INC. **736 SOUTH STONE AVENUE**
LA GRANGE, IL 60525

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	9074	OTHER COMPENSATION	3

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

GALLAGHER BENEFIT SERVICES, INC.

13333 CALIFORNIA STREET, SUITE 206
OMAHA, NE 68154

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5945	0		3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions		7e(5)		
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	

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) **▶ ACCIDENTAL DEATH AND DISMEMBERMENT**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a		193596
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

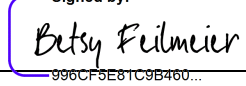
- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- a single-employer plan a DFE (specify) _____
- B** This return/report is: the first return/report the final return/report
- an amended return/report a short plan year return/report (less than 12 months)
- 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 (enter description)
- 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

<p>1a Name of plan <u>FAITH REGIONAL HEALTH SERVICES EMPLOYEE BENEFITS PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>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) <u>FAITH REGIONAL HEALTH SERVICES</u></p> <p><u>1500 KOENIGSTEIN AVENUE</u> <u>NOFOLK, NE 68701</u></p>	<p>1c Effective date of plan <u>01/01/1997</u></p> <p>2b Employer Identification Number (EIN) <u>47-0796875</u></p> <p>2c Plan Sponsor's telephone number <u>402-644-7178</u></p> <p>2d Business code (see instructions) <u>622000</u></p>

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

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

SIGN HERE	Signed by:  996CF5E81C9B460... Signature of plan administrator	6/6/2025	Betsy R Feilmeier
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as plan administrator
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>																																	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																																	
5 Total number of participants at the beginning of the plan year	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">5</td> <td style="text-align: right;">1332</td> </tr> </table>	5	1332																															
5	1332																																	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:80%;"></td> </tr> <tr> <td style="text-align: center;">6a(1)</td> <td style="text-align: center;"></td> <td style="text-align: right;">1332</td> </tr> <tr> <td style="text-align: center;">6a(2)</td> <td style="text-align: center;"></td> <td style="text-align: right;">1337</td> </tr> <tr> <td style="text-align: center;">6b</td> <td style="text-align: center;"></td> <td style="text-align: right;">0</td> </tr> <tr> <td style="text-align: center;">6c</td> <td style="text-align: center;"></td> <td style="text-align: right;">0</td> </tr> <tr> <td style="text-align: center;">6d</td> <td style="text-align: center;"></td> <td style="text-align: right;">1337</td> </tr> <tr> <td style="text-align: center;">6e</td> <td style="text-align: center;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="text-align: center;">6f</td> <td style="text-align: center;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="text-align: center;">6g(1)</td> <td style="text-align: center;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="text-align: center;">6g(2)</td> <td style="text-align: center;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="text-align: center;">6h</td> <td style="text-align: center;"></td> <td style="text-align: right;"></td> </tr> </table>				6a(1)		1332	6a(2)		1337	6b		0	6c		0	6d		1337	6e			6f			6g(1)			6g(2)			6h		
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6g(2)																																		
6h																																		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">7</td> <td style="width:90%;"></td> </tr> </table>	7																																
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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 4B 4D 4E 4F 4G 4H 4L 4Q

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	9b 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 type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 _____
