

<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;">2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	---	--

Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

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>ATHENA HEALTH CARE ASSOCIATES, INC. 401K PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>334</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>ATHENA HEALTH CARE ASSOCIATES, INC.</u></p> <p><u>135 SOUTH ROAD</u> <u>FARMINGTON, CT 06032</u></p>	<p>1c Effective date of plan <u>01/01/1987</u></p> <p>2b Employer Identification Number (EIN) <u>06-1116677</u></p> <p>2c Plan Sponsor's telephone number <u>860-751-3900</u></p> <p>2d Business code (see instructions) <u>623000</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	Filed with authorized/valid electronic signature.	07/11/2025	MICHAEL MOSIER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/11/2025	MICHAEL MOSIER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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	12293
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)	11562
	6a(2)	11373
	6b	34
	6c	835
	6d	12242
	6e	14
	6f	12256
	6g(1)	3256
6g(2)	2960	
6h	152	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
 2E 2F 2G 2J 2K 2T 3D 3H

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

A Name of plan ATHENA HEALTH CARE ASSOCIATES, INC. 401K PLAN		B Three-digit plan number (PN) ▶	334
C Plan sponsor's name as shown on line 2a of Form 5500 ATHENA HEALTH CARE ASSOCIATES, INC.		D Employer Identification Number (EIN) 06-1116677	

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
LINCOLN NATIONAL LIFE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65676	892807-087	12256	10/01/2023	09/30/2024

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

(a) Total amount of commissions paid 57432	(b) Total amount of fees paid 0
---	--

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LPL FINANCIAL **5935 CORNERSTONE CT**
SAN DIEGO, CA 92121

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
57432	0	N/A	7

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

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

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	19389571
5	Current value of plan's interest under this contract in separate accounts at year end.....	96483996
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year.....	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input checked="" type="checkbox"/> other ▶ GIC	
b	Balance at the end of the previous year	7b 19970625
c	Additions: (1) Contributions deposited during the year	7c(1) 1655794
	(2) Dividends and credits	7c(2) 0
	(3) Interest credited during the year	7c(3) 436074
	(4) Transferred from separate account.....	7c(4) 1562510
	(5) Other (specify below)	7c(5) 587747
	▶ LOAN REPAYMENTS	
	(6) Total additions	7c(6) 4242125
d	Total of balance and additions (add lines 7b and 7c(6))	7d 24212750
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 3455401
	(2) Administration charge made by carrier	7e(2) 24987
	(3) Transferred to separate account.....	7e(3) 926248
	(4) Other (specify below)	7e(4) 416543
▶ LOANS		
	(5) Total deductions	7e(5) 4823179
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f 19389571

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

A Name of plan ATHENA HEALTH CARE ASSOCIATES, INC. 401K PLAN	B Three-digit plan number (PN) ▶	334
C Plan sponsor's name as shown on line 2a of Form 5500 ATHENA HEALTH CARE ASSOCIATES, INC.	D Employer Identification Number (EIN) 06-1116677	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LINCOLN NATIONAL CORPORATION

P.O. BOX 7877
FORT WAYNE, IN 46802

35-0472300

(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	SERVICE PROVIDER	143915	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)

PLANNED RETIREMENT CONSULTANTS

555 GOFFLE ROAD, SUITE 200
P.O. BOX 5126
RIDGEWOOD, NJ 07451

45-4208939

(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?
10	CONSULTANT	56887	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)

PFK O'CONNOR DAVIES, LLP

1 CORPORATE DRIVE, STE. 725
SHELTON, CT 06484

27-1728945

(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?
10	AUDITOR	20500	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"/>

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024	
A Name of plan ATHENA HEALTH CARE ASSOCIATES, INC. 401K PLAN	B Three-digit plan number (PN) ▶ 334
C Plan sponsor's name as shown on line 2a of Form 5500 ATHENA HEALTH CARE ASSOCIATES, INC.	D Employer Identification Number (EIN) 06-1116677

Part I	Asset and Liability Statement
---------------	--------------------------------------

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	29763	23285
(2) Participant contributions	1b(2)	169111	129173
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	2347337	2331308
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	83164897	96483997
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	19970599	19389571

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	105681707	118357334
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	105681707	118357334

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	1437944	
(B) Participants	2a(1)(B)	8186574	
(C) Others (including rollovers)	2a(1)(C)	492465	
(2) Noncash contributions	2a(2)	0	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		10116983
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	726542	
(B) U.S. Government securities	2b(1)(B)	0	
(C) Corporate debt instruments	2b(1)(C)	0	
(D) Loans (other than to participants)	2b(1)(D)	0	
(E) Participant loans	2b(1)(E)	170228	
(F) Other	2b(1)(F)	0	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		896770
(2) Dividends:			
(A) Preferred stock	2b(2)(A)	0	
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	5261781	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		5261781
(3) Rents	2b(3)		0
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)	0	
(B) Other	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		0
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		14016184
c Other income	2c		0
d Total income. Add all income amounts in column (b) and enter total	2d		30291718

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	17294727	
(2) To insurance carriers for the provision of benefits.....	2e(2)	0	
(3) Other.....	2e(3)	0	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		17294727
f Corrective distributions (see instructions).....	2f		0
g Certain deemed distributions of participant loans (see instructions)	2g		100062
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)	0	
(2) Contract administrator fees.....	2i(2)	143915	
(3) Recordkeeping fees.....	2i(3)	0	
(4) IQPA audit fees.....	2i(4)	20500	
(5) Investment advisory and investment management fees	2i(5)	0	
(6) Bank or trust company trustee/custodial fees	2i(6)	0	
(7) Actuarial fees	2i(7)	0	
(8) Legal fees	2i(8)	0	
(9) Valuation/appraisal fees	2i(9)	0	
(10) Other trustee fees and expenses	2i(10)	0	
(11) Other expenses	2i(11)	56887	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		221302
j Total expenses. Add all expense amounts in column (b) and enter total	2j		17616091

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		12675627
l Transfers of assets:			
(1) To this plan	2l(1)		0
(2) From this plan	2l(2)		0

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: PFK O'CONNOR DAVIES, LLP

(2) EIN: 27-1728945

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

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

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

A Name of plan ATHENA HEALTH CARE ASSOCIATES, INC. 401K PLAN	B Three-digit plan number (PN) ▶	334
C Plan sponsor's name as shown on line 2a of Form 5500 ATHENA HEALTH CARE ASSOCIATES, INC.	D Employer Identification Number (EIN) 06-1116677	

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	0
---	----------	----------

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
 EIN(s): 56-1354495

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	
--	----------	--

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

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

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

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

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part VII IRS Compliance Questions

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

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

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q704009A.

Athena Health Care Associates, Inc. 401(k) Plan

Financial Statements

September 30, 2024

Independent Auditors' Report

**The Plan Administrator of
Athena Health Care Associates, Inc. 401(k) Plan**

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

We have performed audits of the accompanying financial statements of Athena Health Care Associates, Inc. 401(k) Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as permitted by ERISA Section 103(a)(3)(C) ("ERISA Section 103(a)(3)(C) audit"). The financial statements comprise the statements of net assets available for benefits as of September 30, 2024 and 2023, and the related statement of changes in net assets available for benefits for the year ended September 30, 2024, and the related notes to the financial statements.

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

Management has obtained certifications from a qualified institution as of September 30, 2024 and 2023 and for the year ended September 30, 2024, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Opinion

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

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditors' Responsibilities for the Audit of the Financial Statements

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

Auditors' Responsibilities for the Audit of the Financial Statements (continued)

In performing an audit in accordance with generally accepted auditing standards, we:

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

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

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

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

Supplemental Schedules Required by ERISA

The supplemental Schedule H, Part IV, Line 4a - Schedule of Delinquent Participant Contributions for the year ended September 30, 2024, and Schedule H, Part IV, Line 4i – Schedule of Assets (Held at End of Year) as of September 30, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

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

In our opinion:

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

PKF O'Connor Davies, LLP

Shelton, Connecticut
July 10, 2025

Athena Health Care Associates, Inc. 401(k) Plan

Statements of Net Assets Available for Benefits

	September 30,	
	2024	2023
ASSETS		
Investments, at fair value	\$ 96,483,994	\$ 83,164,897
Investment, at contract value	<u>19,389,574</u>	<u>19,970,599</u>
Total Investments	<u>115,873,568</u>	<u>103,135,496</u>
Receivables		
Employer contributions	23,285	29,763
Participant contributions	129,173	169,111
Notes receivable from participants	<u>2,331,308</u>	<u>2,347,337</u>
Total Receivables	<u>2,483,766</u>	<u>2,546,211</u>
Total Assets	118,357,334	105,681,707
LIABILITIES	<u>-</u>	<u>-</u>
Net Assets Available for Benefits	<u>\$ 118,357,334</u>	<u>\$ 105,681,707</u>

See notes to financial statements

Athena Health Care Associates, Inc. 401(k) Plan

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

ADDITIONS

Contributions	
Employer	\$ 1,437,944
Participants	8,186,574
Rollovers	<u>492,465</u>
Total Contributions	<u>10,116,983</u>
Investment Income	
Net appreciation in value of investments	14,016,184
Interest and dividends	<u>5,988,323</u>
Total Investment Income	<u>20,004,507</u>
Interest on notes receivable from participants	<u>170,228</u>
Total Additions	<u>30,291,718</u>

DEDUCTIONS

Benefits paid to participants	17,394,789
Administrative expenses	<u>221,302</u>
Total Deductions	<u>17,616,091</u>
Net Increase	12,675,627

NET ASSETS AVAILABLE FOR BENEFITS

Beginning of year	<u>105,681,707</u>
End of year	<u>\$ 118,357,334</u>

See notes to financial statements

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

1. Description of the Plan

The following description of Athena Health Care Associates, Inc. 401(k) Plan (the “Plan”) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan’s provisions.

General

The Plan was established to provide retirement benefits for employees of Athena Health Care Associates, Inc., and affiliates (collectively, the “Company”). The following is a listing of the employers included in the Plan:

301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center
2301 Boston Road, LLC DBA The Gardens of Wilbraham
Athena Health Care Associates, Inc.
Athena Home Health, LLC
Athena Home Health of MA, LLC
Athena Hospice Services of Massachusetts, LLC
Athena Hospice Services of Western Massachusetts, LLC
Athena Orchard View, LLC
Berkshire MA SNF, LLC d/b/a Berkshire Rehabilitation & Health Care Center
Cape Heritage MA SNF, LLC d/b/a Cape Heritage Rehabilitation & Health Care Center
Cape Regency MA SNF, LLC d/b/a/ Cape Regency Rehabilitation & Health Care Center
The Commons of Newtown Assisted Living
Heatherwood RI, LLC
Highland View Manor, Inc. d/b/a Litchfield Woods Health Care Center
Lanessa MA SNF, LLC d/b/a Lanessa Extended Care
Marlboro Hills MA SNF, LLC d/b/a Marlborough Hills Rehabilitation & Health Center
Meadowbrook Center, Inc. d/b/a Meadowbrook of Granby
Northbridge Health Care Center, Inc.
Northwood MA SNF, LLC d/b/a Northwood Rehabilitation and Health Care Center
Oakland Grove Associates, LP d/b/a Oakland Grove Health Care Center
Oxford MA SNF, LLC d/b/a Oxford Rehabilitation & Health Care Center
Parsons Hill MA SNF, LLC d/b/a Parsons Hill Rehabilitation & Health Care Center
Rhode Island Hospice, LLC
Plymouth MA, SNF, LLC d/b/a Plymouth Rehabilitation & Health Care Center
Sheriden Woods Health Care Center, Inc. d/b/a Sheriden Woods
Southbridge MA SNF, LLC d/b/a Southbridge Rehabilitation and Health Care Center
Southeast MA SNF, LLC
Southshore MA SNF, LLC
Summit RI SNF, LLC
TCU at Hubbard LLC DBATCU at Hubbard
Tremont MA SNF, LLC
Valerie Manor, Inc. d/b/a Valerie Manor
Wadsworth Glen, Inc. d/b/a Wadsworth Glen Health Care & Rehabilitation Center
Waterview RI SNF, LLC
Webster MA SNF, LLC d/b/a Webster Manor Rehabilitation & Health Care Center
Worcester MA, SNF, LLC d/b/a Worcester Rehabilitation & Health Care Center

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

1. Description of the Plan *(continued)*

General *(continued)*

The following is a list of employers who closed, sold or were no longer managed by the Company during and subsequent to the plan year:

During the plan year:

Athena Middlesex, LLC
Crestfield Rehabilitation Center & Fenwood Manor
Montowese Health & Rehabilitation Center
Leeds MA SNF, LLC d/b/a Highview
Maefair Health Care Center, Inc.
Naugatuck Heath Care Center, LLC d/b/a Beacon Brook Heath Center
Newtown Rehabilitation & Health Care Center
Sharon CT SNF, LLC
Stafford Springs CT SNF, LLC d/b/a Evergreen Health Care Center
Stonehedge MA SNF, LLC

Subsequent to the plan year end:

Abbott Terrace Health Center, Inc.
Athena Holdings, LLC d/b/a Laurel Ridge Health Care Center
Bristol CCH Group, LLC d/b/a Countryside Manor of Bristol and Affiliate
Glastonbury Health Care Center, Inc
Shady Knoll Health Center, Inc. d/b/a Shady Knoll Health Center
Southington SNF, LLC d/b/a Summit of Plantsville

The assets of the closed, sold and no longer manager employers remain in the plan until such time the participant requests a distribution or rollover.

The Plan is a contributory defined contribution plan sponsored by the participating employers for the benefit of eligible employees. Employees become eligible to participate in the Plan on the first day of the next calendar month following the date in which the employee attains age 21 and completes 208 hours of service in a three month period. Plan entry dates are the first day of each month that falls on or after the date eligibility requirements are met.

Contributions

Participants may contribute up to 100% of eligible compensation up to the maximum allowed by the Internal Revenue Code (the "IRC"). Participants may also contribute amounts representing distributions from other qualified retirement plans to the extent permitted by the IRC, regardless of whether they have met the eligibility requirements for participation in the Plan. Each of the participating employers may make discretionary contributions under the Plan. All contributions are subject to certain limitations imposed by the Plan and the Employee Retirement Income Security Act of 1974 ("ERISA").

The Plan has a matching program for participants of the Plan. The matching program provides for a 25% match of employee contributions up to a maximum of 6% of the employee's weekly wages.

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements

September 30, 2024

1. Description of the Plan *(continued)*

Contributions (continued)

Countryside Manor of Bristol 401(k) Plan participants that were contributing to the Plan prior to October 1, 2015 receive employer contributions equal to 50% of the first 4% of participants' pre-tax contributions up to a maximum Company contribution of 2% of compensation.

Participant Accounts

Each participant's account is credited with the participant's contribution and allocations of (a) the Company's contribution and (b) Plan earnings (losses). Allocations are based on a participant's earnings, account balances, or specific participant transactions, as defined.

Vesting

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

<u>Years of Service</u>	<u>Percentage</u>
2	25%
3	50%
4	75%
5 or more	100%

Investment Options

Participants may direct their contributions to a variety of mutual funds and a guaranteed investment contract held at Lincoln Financial Group Trust Company, Inc. ("Lincoln"). These funds include a variety of investment options with various objectives and degrees of financial risk.

Notes Receivable from Participants

Participants may borrow from their accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of the vested portion of their account balance. The Plan permits that up to two loans may be taken at one time. Loan terms range from one to five years. Loans used to acquire a principal residence may be repaid over a reasonable period of time, which may exceed five years. The loans are secured by the vested balance in the participant's account and bear interest at a rate commensurate with local prevailing rates. Principal and interest is paid ratably through payroll deductions.

Payment of Benefits

Upon retirement, disability, death or termination of employment, a participant shall become entitled to the value of his or her vested account determined as of the valuation date. The Plan also provides for in-service withdrawals by qualified individuals. Distributions will be paid by a lump sum or installment payments based upon the election of the participant or the Plan, as defined in the Plan or the IRC.

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

1. Description of the Plan *(continued)*

Payment of Benefits (continued)

Upon financial hardship, the participant is entitled to the value of any of his or her employee accounts, excluding any money purchase account balances, determined as of the valuation date, which is payable immediately in a lump-sum distribution.

Forfeited Accounts

Forfeitures of the non-vested portion of terminated participants' accounts are maintained in a separate account and may be used to pay administrative expenses or to reduce future employer contributions. At September 30, 2024 and 2023, forfeited nonvested accounts totaled \$583,551 and \$389,884. During the year ended September 30, 2024, \$16,482 of employer contributions were reduced from forfeited nonvested accounts.

Plan Expense Account

The Plan and Lincoln Retirement Services Company, LLC entered into a Recordkeeping Service Agreement whereby quarterly credits will be made in arrears to the Plan Expense Account equal to 0.0800% annually of the Plan's total assets, which will be used to pay Plan expenses or to reduce employer contributions. In order for the Plan to receive credits as a result of this arrangement, and to use these credits to reduce employer contributions, the Plan created a Plan Expense Account, which is invested in the Lincoln Stable Value Fund within the Plan. The Plan Expense Account balance was \$114,672 and \$99,079 as of September 30, 2024 and 2023. During the year ended September 30, 2024, \$77,387 from the plan expense account was used to pay for administrative expenses and no amount from the plan expense account were used to reduce employer contributions.

2. Summary of Significant Accounting Policies

Basis of Accounting and Use of Estimates

The accompanying financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"), which requires management to make estimates and assumptions that affect certain reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Fair Value Measurements

The Plan follows U.S. GAAP guidance on *Fair Value Measurements* which defines fair value and establishes a fair value hierarchy organized into three levels based upon the input assumptions used in pricing assets. Level 1 inputs have the highest reliability and are related to assets with unadjusted quoted prices in active markets. Level 2 inputs relate to assets with other than quoted prices in active markets which may include quoted prices for similar

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

2. Summary of Significant Accounting Policies *(continued)*

Fair Value Measurements (continued)

assets or liabilities or other inputs which can be corroborated by observable market data. Level 3 inputs are unobservable and are used to the extent that observable inputs do not exist. At September 30, 2024 and 2023, the Plan's investments, that were valued at fair value (mutual funds), were valued using level 1 inputs.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value, except for the fully-benefit responsive investment contracts, which are reported at contract value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Mutual funds held by the Plan are valued at fair value based on the daily closing price as reported by the funds. All of the mutual funds are open-ended and are registered with the Securities and Exchange Commission. These mutual funds are required to publish their daily net asset value and to transact at that price. These funds are deemed to be actively traded. The guaranteed investment contract is reported at contract value, which represent contributions made under the contracts, plus earnings, less participant withdrawals and administrative expenses.

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

Notes Receivable from Participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. If a participant ceases to make loan repayments and the Plan administrator deems the participant loan to be in default, when a distributable event occurs, the participant loan balance is reduced and a benefit payment is recorded.

Payment of Benefits

Benefits are recorded when paid.

Plan Expenses

Administrative expenses incident to the operation of the Plan are paid by the Plan. The primary expenses paid by the Plan relate to recordkeeping, third-party administration, trust and audit services. Certain other costs for administering the Plan are paid by the Company.

Subsequent Events Evaluation by Management

Management has evaluated subsequent events for disclosure and/or recognition in the financial statements through the date that the financial statements were available to be issued, which date is July 10, 2025.

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

3. Information Certified (Unaudited)

Certain information related to investments and notes receivable from participants disclosed in the accompanying financial statements and ERISA-required Schedule H, Part IV, Line 4i – Schedule of Assets (Held at End of Year) including investments held at September 30, 2024 and 2023 and notes receivable from participants, and net appreciation in value of investments, interest and dividends, and interest income on notes receivable for the year ended September 30, 2024 was obtained by management and agreed to or derived from information certified as complete and accurate by Lincoln, a qualified institution.

4. Guaranteed Investment Contracts

The Plan has entered into a group annuity contract with Lincoln that provides for an investment in the Lincoln Financial Group Stable Value Account (the “Guaranteed Account”). The Guaranteed Account is considered to be fully benefit-responsive in that it provides that participants may make withdrawals, or transfer all or a portion of their account balance, at contract value during the term of the contract. Lincoln maintains the contributions in its general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. There are no reserves against the investment for credit risk of Lincoln or otherwise. The contract value of the Guaranteed Account at September 30, 2024 and 2023 was \$19,389,574 and \$19,970,599.

The contract amount maintained in the Guaranteed Account is guaranteed by Lincoln against loss of principal, less all withdrawals, including charges and adjustments. Interest is credited daily and the contract does not include a minimum interest rate. The interest crediting rate and portfolio crediting rate are declared on a quarterly basis. Deposits in any quarter earn interest at a declared new money rate for that quarter and the next three quarters. When deposits are beyond the initial four-quarter period, they earn interest at the portfolio rate for the corresponding quarter. The Guaranteed Account is credited with a stated interest rate that is restated annually and is backed by the general account of Lincoln. The Guaranteed Account was credited with interest rates of 2.3% and 2.1% for the years ended September 30, 2024 and 2023. The Guaranteed Account represents approximately 17% and 19% of the Plans assets at September 30, 2024 and 2023.

5. Tax Status

The Internal Revenue Service (“IRS”) has determined and informed the prototype document preparer by a letter dated June 30, 2020, that the Plan and related trust are designed in accordance with applicable sections of the IRC. The Plan has been amended since the letter was issued by the IRS, however, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

Athena Health Care Associates, Inc. 401(k) Plan

Notes to Financial Statements
September 30, 2024

5. Tax Status (*continued*)

U.S. GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine examinations by taxing jurisdictions; however, there are currently no examinations for any tax periods in progress.

6. Plan Termination

Although it has not expressed any intent to do so, the Company may at any time terminate the Plan and discontinue all contributions, subject to the applicable provisions of ERISA. In the event the Plan is terminated, all participants shall become fully vested in their account balances.

7. Party-in-Interest Transactions

All investments of the Plan are or were managed by an affiliate of Lincoln. Therefore, these transactions qualify as exempt party-in-interest transactions under ERISA.

The Plan Expense Account is maintained by Lincoln Retirement Services Company, LLC, which receives payments from Lincoln pursuant to a written agreement with the Company. Under the agreement, the Company can use the amounts in the account to pay for administrative expenses incurred by the Plan or to reduce employer contributions. These transactions are considered allowable party-in-interest transactions.

Participants who are active employees may borrow from their accounts and such loans qualify as exempt party-in-interest transactions under ERISA. These loans are recorded as notes receivable from participants in the statements of net assets available for benefits.

8. Prohibited Transaction

During the 2024 and 2023 Plan years, the Company failed to transmit to the Plan certain participants' contributions totaling \$5,330,245 and \$492,048, respectively within the period described by the Department of Labor regulations. Plan management is in the process of correcting these late remittances.

9. Risks and Uncertainties

Investment securities, in general, are exposed to various risks such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

The global and domestic economic uncertainty has resulted in significant volatility in financial markets. This volatility has affected, and may continue to affect, the value of the Plan's net assets available for benefits. The effects of economic and market conditions subsequent to September 30, 2024 are not reflected in these financial statements and future effects on the Plan's net assets available for benefits cannot be predicted.

* * * * *

Athena Health Care Associates, Inc. 401(k) Plan

Supplemental Schedules

September 30, 2024

Athena Health Care Associates, Inc. 401(k) Plan

Schedule Pursuant to Department of Labor Requirements
Year ended September 30, 2024

Schedule H, Part IV, Line 4a – Schedule of Delinquent Participant Contributions

**EIN #: 06-1116677
Plan #: 334**

Participant Contributions Transferred Late to the Plan	Prohibited Transactions Total that Constitutes Nonexempt			Total Fully Corrected Under VFCP and PTE 2002-51
	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
\$ 5,822,293	\$ 5,822,293	\$ -	\$ -	\$ -

Check here if late participant loan payments are included ().

Athena Health Care Associates, Inc. 401(k) Plan

Schedule Pursuant to Department of Labor Requirements
September 30, 2024

Schedule H, Part IV, Line 4i - Schedule of Assets (Held at End of Year)

**EIN #: 06-1116677
Plan #: 334**

(a)	(b) Identity of Issuer, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(e) Current Value
	MUTUAL FUNDS	SHARES/UNITS	
	American Funds Euro Pacific Growth Fund	149,024	\$ 8,978,700
	American Funds Growth Fund of America Common	92,883	7,210,480
	American Funds Intermediate Bond Fund of America	329,389	4,199,704
	American Funds Income Fund of America Common	212,616	5,519,521
	American Funds Fundamental Investors Inc. Common	162,364	13,875,644
	American Funds New Perspective Fund Common	58,317	3,843,691
	Bank of New York Mellon SP 500 Stock Index	99,319	6,277,953
	Columbia Dividend Income Fund	193,904	6,776,952
	Invesco Developing Markets Fund	67,617	2,845,987
	JP Morgan Core Bond Class A	1,886,749	19,867,465
	Eaton Vance Atlantic Capital Small and Mid Cap Fund	84,275	3,133,344
	Lord Abbett High Yield Fund	420,303	2,723,561
	MFS Mid Cap Value Fund	136,924	4,732,108
	Parametric Commodity Strategy Institutional	241,839	1,588,883
	Hood River Small Cap Growth Class Institutional	21,663	1,616,270
	Baron Real Estate Institutional Shares	18,067	747,625
	Loomis Sayles Global Allocation	5,892	158,780
	Goldman Sachs Small Cap Value Insights Investor	43,026	1,795,475
	AMG River Road Small Mid Cap Value	58,599	591,851
	Total Investments at Fair Value		<u>96,483,994</u>
	GUARANTEED INVESTMENT CONTRACTS		
*	Lincoln Financial Group Stable Value Contract	16,089,579	19,389,574
	Total Investments		<u>115,873,568</u>
*	NOTES RECEIVABLE FROM PARTICIPANTS	Loans have interest rates ranging from 3.25% to 9.50% with maturities through 2044	<u>2,331,308</u>
			<u>\$ 118,204,876</u>

* - Denotes a party-in-interest as defined by ERISA.

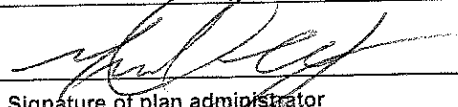
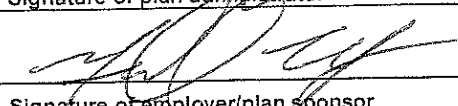
Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the 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.	OMB Nos. 1210-0110 1210-0069 2023 This Form is Open to Public Inspection
---	--	---

Part I Annual Report Identification Information	
For calendar plan year 2023 or fiscal plan year beginning	10/01/2023 and ending 09/30/2024
A This return/report is for:	<input type="checkbox"/> a multiemployer plan <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a DFE (specify) _____
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here:	<input type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> special extension (enter description) <input type="checkbox"/> the DFVC program
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here:	<input type="checkbox"/>

Part II Basic Plan Information—enter all requested information											
1a Name of plan Athena Health Care Associates, Inc. 401k Plan	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">334</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">01/01/1987</td> </tr> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">06-1116677</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">860-751-3900</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">623000</td> </tr> </table>	1b Three-digit plan number (PN) ▶	334	1c Effective date of plan	01/01/1987	2b Employer Identification Number (EIN)	06-1116677	2c Plan Sponsor's telephone number	860-751-3900	2d Business code (see instructions)	623000
1b Three-digit plan number (PN) ▶	334										
1c Effective date of plan	01/01/1987										
2b Employer Identification Number (EIN)	06-1116677										
2c Plan Sponsor's telephone number	860-751-3900										
2d Business code (see instructions)	623000										
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) ATHENA HEALTH CARE ASSOCIATES, INC. 135 SOUTH ROAD FARMINGTON CT 06032											

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		7/11/25	MICHAEL MOSIER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		7/11/25	MICHAEL MOSIER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Name of Plan: Athena Health Care Associates, Inc. 401(k) Plan
 EIN: 06-1116677
 PN: 334

Schedule H, line 4i - Schedule of Assets (Held at End of Year)

(a)	(b) Identity of issue, borrower, lesser, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
*	AM FDS EUROPACIFIC GROWTH A	Value of interest in mutual fund	**	\$8,978,700
*	AM FDS GROWTH FUND OF AMERICA A	Value of interest in mutual fund	**	\$7,210,480
*	AM FDS INT BOND OF AMERICA A	Value of interest in mutual fund	**	\$4,199,704
*	AM FDS INCOME FUND OF AMERICA A	Value of interest in mutual fund	**	\$5,519,521
*	AM FDS FUNDAMENTAL INVESTORS	Value of interest in mutual fund	**	\$13,875,644
*	AM FDS NEW PERSPECTIVE A	Value of interest in mutual fund	**	\$3,843,691
*	BNY MELLON INST S&P 500 STOCK INDEX	Value of interest in mutual fund	**	\$6,277,953
*	COLMBIA DIVIDEND INCOME FD A	Value of interest in mutual fund	**	\$6,776,952
*	INVESCO DEVELOPING MARKETS A	Value of interest in mutual fund	**	\$2,845,987
*	JPM CORE BOND A	Value of interest in mutual fund	**	\$19,867,465
*	HOOD RIVER SMCP GROWTH	Value of interest in mutual fund	**	\$1,616,270
*	ETN VCN ATLANTIC CAPITAL SMID CAP A	Value of interest in mutual fund	**	\$3,133,344
*	LRD ABT HIGH YIELD FUND	Value of interest in mutual fund	**	\$2,723,561
*	MFS MID CAP VALUE	Value of interest in mutual fund	**	\$4,732,108
*	BARON REAL ESTATE	Value of interest in mutual fund	**	\$747,625
*	LINCOLN STABLE VALUE F64S	Guaranteed Investment Contract	**	\$19,389,574
*	PARAMETRIC COMMODITY STRATEGY	Value of interest in mutual fund	**	\$1,588,883
*	LOOMIS SAYLESGLOBAL ALLOCATION	Value of interest in mutual fund	**	\$158,780
*	GOLDMAN SACHS SMCP VALUE INSGT	Value of interest in mutual fund	**	\$1,795,475
*	AMG RIVER SMALL MID CAP VALUE	Value of interest in mutual fund	**	<u>\$591,851</u>
				\$115,873,568
*	PARTICIPANT LOANS	Interest rates ranging from 3.25% - 9.25%		<u>\$2,331,308</u>
				\$118,204,876
	* Party-in-interest			
	** Cost omitted for participant directed funds			