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| <p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: small;">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 style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p> |
|---|---|---|

Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

| | |
|--|--|
| <p>1a Name of plan <u>STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>002</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>STANFORD HEALTH CARE</u></p> <p><u>300 PASTEUR DRIVE, MC 5513</u> <u>STANFORD, CA 94305-5513</u></p> | <p>1c Effective date of plan <u>03/01/1981</u></p> <p>2b Employer Identification Number (EIN) <u>94-6174066</u></p> <p>2c Plan Sponsor's telephone number <u>650-498-5349</u></p> <p>2d Business code (see instructions) <u>622000</u></p> |

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

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

| | | | |
|------------------|---|------------|--|
| SIGN HERE | Filed with authorized/valid electronic signature. | 07/31/2025 | MARGARET WILSON |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 07/31/2025 | DIANA JANIS |
| | 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: | | 4b EIN | |
| a Sponsor's name | | 4d PN | |
| c Plan Name | | | |
| 5 Total number of participants at the beginning of the plan year | 5 | 37643 | |
| 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). | | | |
| 6a(1) Total number of active participants at the beginning of the plan year | 6a(1) | 24152 | |
| 6a(2) Total number of active participants at the end of the plan year | 6a(2) | 25626 | |
| b Retired or separated participants receiving benefits | 6b | 722 | |
| c Other retired or separated participants entitled to future benefits | 6c | 12685 | |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d | 39033 | |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e | 242 | |
| f Total. Add lines 6d and 6e | 6f | 39275 | |
| g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | 6g(1) | 36192 | |
| g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g(2) | 38126 | |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h | 0 | |
| 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:
 2F 2L 2M 2R 2T 2G 3F 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 |
| (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 |
| (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"/> I (Financial Information – Small Plan) | (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>6</u> |
| (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (4) <input checked="" type="checkbox"/> C (Service Provider Information) | (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) | (6) <input type="checkbox"/> G (Financial Transaction Schedules) |
| (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | | | |
| (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ | | | |
| (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information) | | | |

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

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

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

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

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

Receipt Confirmation Code _____

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

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

| | | |
|--|--|-------------------|
| <p>A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>002</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE</p> | <p>D Employer Identification Number (EIN) 94-6174066</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 22-1211670 | 68241 | 524598-01 | 19 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|----------|--------|
| 4 Current value of plan's interest under this contract in the general account at year end | 4 | 467228 |
| 5 Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 286675 |

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) individual policies (2) group deferred annuity
 (3) other (specify) ▶

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

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

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

b Balance at the end of the previous year **7b** 543532

| | | |
|---|--------------|-------|
| c Additions: (1) Contributions deposited during the year | 7c(1) | |
| | 7c(2) | |
| | 7c(3) | 16129 |
| | 7c(4) | |
| | 7c(5) | |

(6) Total additions **7c(6)** 16129

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d** 559661

e Deductions:

| | | |
|---|--------------|-------|
| (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | 92433 |
| (2) Administration charge made by carrier..... | 7e(2) | |
| (3) Transferred to separate account | 7e(3) | |
| (4) Other (specify below) | 7e(4) | |

(5) Total deductions **7e(5)** 92433

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 467228

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. ▶

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

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

| | | |
|--|--|-------------------|
| <p>A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>002</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE</p> | <p>D Employer Identification Number (EIN) 94-6174066</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 35-0472300 | 65676 | 092266-031 | 14 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|----------------------------|--|-------------------|
| | Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 70672 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | |
| 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 checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 68595 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 2575 |
| | (4) Transferred from separate account | 7c(4) |
| | (5) Other (specify below)..... ▶ | 7c(5) |
| | (6) Total additions | 7c(6) 2575 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 71170 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 498 |
| | (2) Administration charge made by carrier..... | 7e(2) |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ | 7e(4) |
| (5) Total deductions | 7e(5) 498 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 70672 |

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 A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

| | | |
|--|--|--|
| A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN | | B Three-digit plan number (PN) ▶ 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE | | D Employer Identification Number (EIN) 94-6174066 |

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

NEW YORK LIFE

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
| | | | | (f) From | (g) To |
| 13-5582869 | 66915 | TT069432 | 10000 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|----------------------------|--|-----------------------|
| | Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 65508123 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 0 |
| 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 checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 73583620 |
| c | (1) Contributions deposited during the year | 7c(1) 4301438 |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 2024722 |
| | (4) Transferred from separate account | 7c(4) |
| | (5) Other (specify below)..... ▶ LOAN REPAYMENTS, EXCHANGE IN, ADJUSTMENT | 7c(5) 14516474 |
| | (6) Total additions | 7c(6) 20842634 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 94426254 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 9765639 |
| | (2) Administration charge made by carrier..... | 7e(2) 11764 |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ LOAN WITHDRAWAL, EXCHANGE OUT | 7e(4) 19140728 |
| (5) Total deductions | 7e(5) 28918131 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 65508123 |

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 A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

| | |
|--|--|
| A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN | B Three-digit plan number (PN) ▶ 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE | D Employer Identification Number (EIN) 94-6174066 |

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

TIAA-CREF

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
| | | | | (f) From | (g) To |
| 13-1624203 | 69345 | 101068 | 5700 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|----------------------------|--|-----------------------|
| | Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 148040715 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 9014656 |
| 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 checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 153363827 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 6515975 |
| | (4) Transferred from separate account | 7c(4) |
| | (5) Other (specify below)..... ▶ NET INTERFUND TRANSFERS | 7c(5) 850150 |
| | (6) Total additions | 7c(6) 7366125 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 160729952 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 12327562 |
| | (2) Administration charge made by carrier..... | 7e(2) 6752 |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ PLAN TO PLAN TRANSFER OUT | 7e(4) 354923 |
| (5) Total deductions | 7e(5) 12689237 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 148040715 |

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. Specify nature of costs. | 10b | |

Part IV Provision of Information

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

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

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

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

| | | |
|--|--|-------------------|
| <p>A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>002</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE</p> | <p>D Employer Identification Number (EIN) 94-6174066</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
TIAA-CREF

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 13-1624203 | 69345 | 101067 | 0 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|----------|------|
| 4 Current value of plan's interest under this contract in the general account at year end | 4 | 1572 |
| 5 Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 0 |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

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 ▶

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

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

| | |
|-----------|--|
| 6b | |
| 6c | |
| 6d | |

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

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

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year

(2) Dividends and credits.....

(3) Interest credited during the year.....

(4) Transferred from separate account

(5) Other (specify below).....
 ▶

(6) Total additions

d Total of balance and additions (add lines **7b** and **7c(6)**)

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

(2) Administration charge made by carrier.....

(3) Transferred to separate account

(4) Other (specify below).....
 ▶

(5) Total deductions

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**).....

| | | |
|--------------|----|------|
| 7b | | 1517 |
| 7c(1) | | |
| 7c(2) | | |
| 7c(3) | 55 | |
| 7c(4) | | |
| 7c(5) | | |
| 7c(6) | | 55 |
| 7d | | 1572 |
| 7e(1) | | |
| 7e(2) | | |
| 7e(3) | | |
| 7e(4) | | |
| 7e(5) | | 0 |
| 7f | | 1572 |

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. ▶

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

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

| | | |
|--|--|-------------------|
| <p>A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>002</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE</p> | <p>D Employer Identification Number (EIN) 94-6174066</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 22-1211670 | 68241 | 524214-03 | 3 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|----------------------------|--|---------------------|
| | Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 279016 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | |
| 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 checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 494921 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 16610 |
| | (4) Transferred from separate account | 7c(4) |
| | (5) Other (specify below)..... ▶ | 7c(5) |
| | (6) Total additions | 7c(6) 16610 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 511531 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 232515 |
| | (2) Administration charge made by carrier..... | 7e(2) |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ | 7e(4) |
| (5) Total deductions | 7e(5) 232515 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 279016 |

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> 2024 This Form is Open to Public Inspection. |
|--|--|---|

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

| | | |
|--|--|------------|
| A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN | B Three-digit plan number (PN) ▶ | 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE | D Employer Identification Number (EIN) 94-6174066 | |

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

EMPOWER ANNUITY INSURANCE COMPANY **8515 EAST ORCHARD ROAD**
GREENWOOD VILLAGE, CO 80111

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

LINCOLN NATIONAL CORPORATION

35-1140070

(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

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(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)

FIDELITY INSTITUTIONAL OPERATIONS C

04-2647786

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 50 65 37 99 64 | NONE | 1710838 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

MOSS ADAMS

91-0189318

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 50 10 | NONE | 18300 | 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)

TIAA - TEACHERS INSURANCE AND ANNUI

13-1624203

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 50 64 65 | NONE | 6752 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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)

WILLIS TOWERS WATSON

53-0181291

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 50 16 | NONE | 5407 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

| | |
|--|----------------------------------|
| a Name: MOSS ADAMS, LLP | b EIN: 91-0189318 |
| c Position: AUDITOR | |
| d Address: 6565 AMERICAS PARKWAY NE SUITE 600 ALBUQUERQUE, NM 87122 | e Telephone: 408-558-7500 |

Explanation: MOSS ADAMS, LLP MERGED WITH BAKER TILLY US, LLP ON JUNE 3, 2025

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

| | | |
|---|--|--|
| SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> | DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. | OMB No. 1210-0110 <hr/> 2024 This Form is Open to Public Inspection. |
|---|--|--|

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

| | | |
|---|--|------------|
| A Name of plan <u>STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</u> | B Three-digit plan number (PN) ▶ | <u>002</u> |
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>STANFORD HEALTH CARE</u> | D Employer Identification Number (EIN) <u>94-6174066</u> | |

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

| | | | | |
|--|-------------------------------|---|----------------|--|
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>TIAA REAL ESTATE</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>TIAA-CREF</u> | | | | |
| c EIN-PN <u>13-1624203-004</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>9014656</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PSF PGIM TOTAL RET BOND</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-083</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>1092</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PSF PGIM 50/50 BALANCED</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-087</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>3785</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PSF PGIM FLEXIBLE MANAGED</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-086</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>66431</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PSF STOCK INDEX PORTFOLIO</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-070</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>6001</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PRUDENTIAL CAPITAL GROWTH</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-005</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>110714</u> | |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MEDLEY PSF PGIM JENNISON BLEND</u> | | | | |
| b Name of sponsor of entity listed in (a): <u>PRUDENTIAL INSURANCE COMPANY OF AMERICA</u> | | | | |
| c EIN-PN <u>22-1211670-069</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | <u>30514</u> | |

a Name of MTIA, CCT, PSA, or 103-12 IE: MEDLEY PSF GLOBAL PORTFOLIO

b Name of sponsor of entity listed in (a): PRUDENTIAL INSURANCE COMPANY OF AMERICA

| | | |
|--------------------------------|------------------------|---|
| c EIN-PN 22-1211670-071 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 66193 |
|--------------------------------|------------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE: MEDLEY PSF PGIM GOV'T MM PORTFOLIO

b Name of sponsor of entity listed in (a): PRUDENTIAL INSURANCE COMPANY OF AMERICA

| | | |
|--------------------------------|------------------------|--|
| c EIN-PN 22-1211670-025 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1946 |
|--------------------------------|------------------------|--|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|--|--|
| SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection |
|--|--|--|

| | |
|--|--|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 | |
| A Name of plan STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN | B Three-digit plan number (PN) ▶ 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 STANFORD HEALTH CARE | D Employer Identification Number (EIN) 94-6174066 |

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

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

| | | (a) Beginning of Year | (b) End of Year |
|--|-----------------|-----------------------|-----------------|
| Assets | | | |
| a Total noninterest-bearing cash | 1a | | |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 508040 | 10336580 |
| (2) Participant contributions | 1b(2) | 34745 | 14709 |
| (3) Other | 1b(3) | | |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 637154 | 608022 |
| (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) | 41282348 | 49611176 |
| (9) Value of interest in common/collective trusts | 1c(9) | | |
| (10) Value of interest in pooled separate accounts | 1c(10) | 11460569 | 9301332 |
| (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) | 4915997980 | 6003816937 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | 621792653 | 635902499 |
| (15) Other | 1c(15) | 169790653 | 221695260 |

| 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 | 5761504142 | 6931286515 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | | |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 61000 | 61000 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 61000 | 61000 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 5761443142 | 6931225515 |

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) | 309088036 | |
| (B) Participants..... | 2a(1)(B) | 328991711 | |
| (C) Others (including rollovers)..... | 2a(1)(C) | 39752738 | |
| (2) Noncash contributions..... | 2a(2) | | |
| (3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)..... | 2a(3) | | 677832485 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 28608 | |
| (B) U.S. Government securities..... | 2b(1)(B) | | |
| (C) Corporate debt instruments..... | 2b(1)(C) | | |
| (D) Loans (other than to participants)..... | 2b(1)(D) | | |
| (E) Participant loans..... | 2b(1)(E) | 3377185 | |
| (F) Other..... | 2b(1)(F) | 8576066 | |
| (G) Total interest. Add lines 2b(1)(A) through (F)..... | 2b(1)(G) | | 11981859 |
| (2) Dividends: | | | |
| (A) Preferred stock..... | 2b(2)(A) | | |
| (B) Common stock..... | 2b(2)(B) | | |
| (C) Registered investment company shares (e.g. mutual funds)..... | 2b(2)(C) | 167362138 | |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C)..... | 2b(2)(D) | | 167362138 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | | |
| (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) | | |
| (7) Net investment gain (loss) from pooled separate accounts | 2b(7) | | -391548 |
| (8) Net investment gain (loss) from master trust investment accounts | 2b(8) | | |
| (9) Net investment gain (loss) from 103-12 investment entities | 2b(9) | | |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) | 2b(10) | | 617313010 |
| c Other income | 2c | | 31749666 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 1505847610 |

Expenses

| | | | |
|---|---------------|-----------|-----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 334198342 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | | |
| (3) Other | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 334198342 |
| f Corrective distributions (see instructions) | 2f | | |
| g Certain deemed distributions of participant loans (see instructions) | 2g | | |
| h Interest expense | 2h | | |
| i Administrative expenses: | | | |
| (1) Salaries and allowances | 2i(1) | | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Recordkeeping fees | 2i(3) | 1712215 | |
| (4) IQPA audit fees | 2i(4) | 18300 | |
| (5) Investment advisory and investment management fees | 2i(5) | | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | | |
| (7) Actuarial fees | 2i(7) | | |
| (8) Legal fees | 2i(8) | | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses | 2i(11) | 136380 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 1866895 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 336065237 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|------------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 1169782373 |
| l Transfers of assets: | | | |
| (1) To this plan | 2l(1) | | |
| (2) From this plan | 2l(2) | | |

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **BAKER TILLY US, LLP**

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

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

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

Part IV Compliance Questions

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

During the plan year:

| | Yes | No | Amount |
|--|-----|----|----------|
| 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 | | 25000000 |
| 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> 2024 This Form is Open to Public Inspection. |
|--|---|---|

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

| | | |
|--|--|------------|
| A Name of plan <u>STANFORD HEALTH CARE RETIREMENT SAVINGS PLAN</u> | B Three-digit plan number (PN) ▶ | <u>002</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>STANFORD HEALTH CARE</u> | D Employer Identification Number (EIN) <u>94-6174066</u> | |

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

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

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

| | | |
|---|--|---|
| 1 | | 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): 13-3689044 13-1624203

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 | | 1487 |
|---|--|------|

| | |
|----------------|---|
| 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 ___/___/____ (MM/DD/YYYY) and the Opinion Letter serial number _____.

*Report of Independent Auditors and
Financial Statements with Supplemental Schedule*

Stanford Health Care Retirement Savings Plan

December 31, 2024 and 2023



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Report of Independent Auditors

The Plan Administrator of
Stanford Health Care Retirement Savings Plan

Report on the Audit of the Financial Statements

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

We have performed audits of the financial statements of Stanford Health Care Retirement Savings Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statements of net assets available for benefits as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of Stanford Health Care Retirement Savings 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 institutions).

Management has obtained certifications from qualified institutions as of December 31, 2024 and 2023, and for the years then ended, stating that the certified investment information, as described in Note 5 to the financial statements, is complete and accurate.

Opinion

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

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with GAAP, 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 Stanford Health Care Retirement Savings Plan's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

- exercise professional judgment and maintain professional skepticism throughout the audit.
- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Stanford Health Care Retirement Savings 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 Stanford Health Care Retirement Savings Plan's ability to continue as a going concern for a reasonable period of time.

Our audits did not extend to the certified investment information, except for obtaining and reading the certifications, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of GAAP.

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 GAAP.

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

Other Matter

Supplemental Schedule Required by ERISA

The Schedule H, Line 4(i) – Schedule of Assets (Held at End of Year) as of December 31, 2024 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedule, other than that agreed to or derived from the certified investment information, has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. For information included in the supplemental schedule that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

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

In our opinion:

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

Baker Tilly US, LLP

Albuquerque, New Mexico
July 30, 2025

Financial Statements

Stanford Health Care Retirement Savings Plan
Statements of Net Assets Available for Benefits
December 31, 2024 and 2023

| | <u>2024</u> | <u>2023</u> |
|------------------------------------|-------------------------|-------------------------|
| Assets | | |
| Investments, at fair value | | |
| Interest-bearing cash | \$ 608,022 | \$ 637,154 |
| Registered investment companies | 6,425,352,110 | 5,309,734,623 |
| Pooled separate accounts | 9,301,332 | 11,460,569 |
| Self-directed brokerage accounts | 221,695,260 | 169,790,653 |
| Fixed annuity contract | 103,950,396 | 107,722,252 |
| | <u>6,760,907,120</u> | <u>5,599,345,251</u> |
| Investments, at contract value | | |
| Guaranteed interest accounts | 66,254,367 | 74,622,073 |
| Fixed annuity contract | 44,091,891 | 45,643,090 |
| Guaranteed income account | 70,672 | 68,595 |
| | <u>110,416,930</u> | <u>120,333,758</u> |
| Total investments | <u>6,871,324,050</u> | <u>5,719,679,009</u> |
| Receivables | | |
| Employer contributions | 10,336,580 | 508,040 |
| Participant contributions | 14,709 | 34,745 |
| Notes receivable from participants | 49,611,176 | 41,282,348 |
| | <u>59,962,465</u> | <u>41,825,133</u> |
| Total assets | 6,931,286,515 | 5,761,504,142 |
| Liabilities | | |
| Administrative expenses payable | <u>61,000</u> | <u>61,000</u> |
| Net assets available for benefits | <u>\$ 6,931,225,515</u> | <u>\$ 5,761,443,142</u> |

Stanford Health Care Retirement Savings Plan
Statements of Changes in Net Assets Available for Benefits
Years Ended December 31, 2024 and 2023

| | <u>2024</u> | <u>2023</u> |
|--|--------------------------------|--------------------------------|
| Additions to net assets attributed to | | |
| Investment income | | |
| Dividends and interest | \$ 185,789,665 | \$ 120,963,039 |
| Net realized and unrealized appreciation in fair value of investments | <u>638,848,275</u> | <u>746,766,296</u> |
| Total investment income | <u>824,637,940</u> | <u>867,729,335</u> |
| Interest income from notes receivable from participants | <u>3,377,185</u> | <u>2,183,102</u> |
| Contributions | | |
| Participant | 368,744,449 | 319,330,887 |
| Employer | <u>309,088,036</u> | <u>264,047,720</u> |
| Total contributions | <u>677,832,485</u> | <u>583,378,607</u> |
| Total additions | <u>1,505,847,610</u> | <u>1,453,291,044</u> |
| Deductions from net assets attributed to | | |
| Withdrawals and distributions | 334,198,342 | 225,926,287 |
| Administrative expenses | <u>1,866,895</u> | <u>1,591,579</u> |
| Total deductions | <u>336,065,237</u> | <u>227,517,866</u> |
| Net increase in net assets | 1,169,782,373 | 1,225,773,178 |
| Net assets available for benefits | | |
| Beginning of year | <u>5,761,443,142</u> | <u>4,535,669,964</u> |
| End of year | <u><u>\$ 6,931,225,515</u></u> | <u><u>\$ 5,761,443,142</u></u> |

Stanford Health Care Retirement Savings Plan

Notes to Financial Statements

NOTE 1 – THE PLAN AND ITS SIGNIFICANT ACCOUNTING POLICIES

General – The following description of Stanford Health Care Retirement Savings Plan (the Plan) provides only general information. Participants should refer to the plan document (Plan Document) for a more complete description of the Plan’s provisions.

The Plan is a 403(b) defined contribution retirement plan that was established in 1981 by Stanford Health Care (SHC) to provide benefits to eligible employees, as defined in the Plan Document. The Plan is currently designed to be qualified under the applicable requirements of the Internal Revenue Code (the Code) and the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Effective December 23, 2012, SHC employees leased to Lucile Packard Children’s Hospital (LPCH) became employees of LPCH and are no longer leased. The SHC benefit plans were amended to include LPCH as a participating employer.

The Plan was amended and restated effective January 1, 2024.

Administration – SHC has appointed the Retirement Committee (the Committee) to manage the operation and administration of the Plan.

SHC has contracted with Fidelity Management Trust Company (Fidelity), Teachers Insurance and Annuity Association of America (TIAA), College Retirement Equities Fund (CREF), The Lincoln National Life Insurance Company (Lincoln), and Empower Annuity Insurance Company (Empower) to act as the custodians.

TIAA and CREF, Lincoln, and Empower are “frozen” vendors. The frozen vendors are not permitted to receive new contributions or transfers from the other custodians, but participant balances held by the frozen vendors may be transferred to Fidelity. The frozen vendors administer the participant accounts they hold, and Fidelity administers the participant accounts held by Fidelity. Substantially all expenses incurred for administering the Plan are paid by the Plan.

Estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Basis of accounting – The financial statements of the Plan are prepared on the accrual method of accounting in accordance with GAAP.

Investment valuation and income recognition – The investments are reported at fair value and contract value. The Plan’s custodians certify the contract value of the guaranteed interest accounts, fixed annuity contract and guaranteed income account and the fair market value of all other investments. If available, quoted market prices are used to value investments.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 2 for discussion of fair value measurements.

Stanford Health Care Retirement Savings Plan

Notes to Financial Statements

Contract value is the relevant measurement for assets invested in fully benefit-responsive investment contracts because contract value is the amount participants normally would receive if they were to initiate permitted transactions under the terms of the Plan.

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 includes the Plan's gains and losses on investments bought or sold as well as held during the year.

Notes receivable from participants – Notes receivable from participants (notes receivable) are measured at their unpaid principal balance plus any accrued but unpaid interest. Delinquent notes receivable are reclassified as distributions upon the occurrence of a distributable event based upon the terms of the Plan Document. No allowance for credit losses has been recorded as of December 31, 2024 or 2023.

Income taxes – The Plan has been designed to qualify under Section 403(b) of the Code. The terms of the Plan have been prepared to conform with the sample language provided by the Internal Revenue Service. The Plan is required to operate in conformity with the Code to maintain the tax-exempt status for participants under Section 403(b).

In accordance with guidance on accounting for uncertainty in income taxes (ASC 740-10), management evaluated the Plan's tax positions and does not believe the Plan has any uncertain tax positions that require disclosure or adjustment to the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Risks and uncertainties – The Plan provides for various investment options in any combination of investment securities offered by the Plan. Investment securities are exposed to various risks, such as interest rate, market fluctuations, and credit risks. Due to the risk associated with certain investment securities, it is at least reasonably possible that changes in market values, interest rates, or other factors in the near term would materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

Subsequent events – The Plan has evaluated subsequent events through July 30, 2025, which is the date the financial statements were available to be issued.

NOTE 2 – FAIR VALUE MEASUREMENTS

The fair value measurements standard establishes a framework for measuring fair value. That framework provides a hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under the standard are described below:

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

Level 2 – Inputs to the valuation methodology include:

- Quoted market prices for similar assets or liabilities in active markets;

Stanford Health Care Retirement Savings Plan

Notes to Financial Statements

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

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

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

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

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Interest-bearing cash: Valued at cost plus accrued interest, which approximates fair value.

Registered investment companies (mutual funds): Valued at the daily closing price as reported by the fund. Mutual funds and money market accounts held by the Plan are open-end funds/accounts that are registered with the U.S. Securities and Exchange Commission. These mutual funds and money market accounts are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds and money market accounts held by the Plan are deemed to be actively traded.

Pooled separate accounts: Units held in pooled separate accounts (PSAs) are valued using the NAV practical expedient of the PSA as reported by the account managers. The NAV practical expedient is based on the fair value of the underlying assets owned by the PSA, minus its liabilities, and then divided by the number of units outstanding. These accounts may be redeemed daily without restrictions and unfunded commitments.

Self-directed brokerage accounts: Accounts primarily consist of registered investment companies that are valued on the basis of readily determinable market prices.

Nonfully benefit-responsive fixed annuity contract: Valued at fair value determined by the sum of the accumulated cash contributions and interest credited to the Plan's contract, less any withdrawals. Fair value is determined and reported to the Plan by TIAA and CREF. Investments in the contract are intended to be held until maturity. Early liquidation could result in a termination charge.

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

Stanford Health Care Retirement Savings Plan Notes to Financial Statements

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023:

| | 2024 | | | Total |
|---|--------------------------------|--------------------|------------------------------|--------------------------------|
| | Level 1 | Level 2 | Level 3 | |
| Interest-bearing cash | \$ 608,022 | \$ - | \$ - | \$ 608,022 |
| Registered investment companies | 6,425,352,110 | - | - | 6,425,352,110 |
| Self-directed brokerage accounts | 221,695,260 | - | - | 221,695,260 |
| Fixed annuity contract | - | - | 103,950,396 | 103,950,396 |
| Total assets in the fair value hierarchy | <u>\$ 6,647,655,392</u> | <u>\$ -</u> | <u>\$ 103,950,396</u> | 6,751,605,788 |
| Investments measured at NAV practical expedient | | | | <u>9,301,332</u> |
| Investments at fair value | | | | <u><u>\$ 6,760,907,120</u></u> |
| | | | | |
| | 2023 | | | Total |
| | Level 1 | Level 2 | Level 3 | |
| Interest-bearing cash | \$ 637,154 | \$ - | \$ - | \$ 637,154 |
| Registered investment companies | 5,309,734,623 | - | - | 5,309,734,623 |
| Self-directed brokerage accounts | 169,790,653 | - | - | 169,790,653 |
| Fixed annuity contract | - | - | 107,722,252 | 107,722,252 |
| Total assets in the fair value hierarchy | <u>\$ 5,480,162,430</u> | <u>\$ -</u> | <u>\$ 107,722,252</u> | 5,587,884,682 |
| Investments measured at NAV practical expedient | | | | <u>11,460,569</u> |
| Investments at fair value | | | | <u><u>\$ 5,599,345,251</u></u> |

The table below sets forth a summary of changes in the fair value of the Plan's Level 3 assets for the years ended December 31:

| | 2024 | 2023 |
|-----------------------------|------------------------------|------------------------------|
| Balance, beginning of year | \$ 107,722,252 | \$ 109,416,774 |
| Purchases | 19,848,088 | 14,140,497 |
| Sales | (23,619,944) | (15,835,019) |
| Balance, end of year | <u>\$ 103,950,396</u> | <u>\$ 107,722,252</u> |

Stanford Health Care Retirement Savings Plan

Notes to Financial Statements

Quantitative information about significant unobservable inputs used in Level 3 fair value measurements:

| Name | December 31, 2024 fair value | December 31, 2023 fair value | Valuation technique | Unobservable inputs | Range of input values/ (weighted average) |
|--|------------------------------------|------------------------------------|----------------------|-----------------------------|---|
| TIAA Traditional GIC Fund (Nonfully benefit-responsive) | \$ 103,950,396 | \$ - | Discounted cash flow | Risk-adjusted discount rate | 3.65% to 6.50% |
| TIAA Traditional GIC Fund (Nonfully benefit-responsive) | \$ - | \$ 107,722,252 | Discounted cash flow | Risk-adjusted discount rate | 4.00% to 6.75% |

NOTE 3 – RELATED-PARTY TRANSACTIONS

Certain plan investments are managed by the custodians of the Plan. Any purchases and sales of these funds are performed in the open market at fair value. Such transactions, while considered party-in-interest transactions under ERISA regulations, are permitted under the provisions of the Plan and are specifically exempt from the prohibition of party-in-interest transactions under ERISA.

NOTE 4 – PARTICIPATION AND BENEFITS

Participant contributions – Participants may elect to have SHC or LPCH contribute their eligible pre-tax or after-tax compensation to the Plan up to the amount allowable under the Plan Document and current income tax regulations. Effective January 1, 2024, participants may elect to make some or all of the participant's eligible pre-tax salary reduction contributions as Roth contributions.

Participants who have SHC or LPCH contribute a portion of their compensation to the Plan agree to accept an equivalent reduction in taxable or taxed compensation. Contributions withheld are invested in accordance with the participant's direction.

Employer contributions – SHC and LPCH are allowed to make basic and matching contributions, as defined in the Plan. In 2024 and 2023, SHC and LPCH made basic contributions of 5% of each eligible participant's basic compensation, as defined in the Plan Document. In 2024 and 2023, SHC and LPCH made employer matching contributions of 5%, 6%, or 8% of each eligible participant's basic compensation, depending on years of eligible service, as defined in the Plan Document.

Vesting – Participants are immediately vested in their entire account, including employer contributions.

Participant accounts – Each participant's account is credited with the participant's contribution, plan earnings or losses, and an allocation of the SHC or LPCH contributions, if any. Allocation of the SHC or LPCH contributions is based on participant contributions or eligible employee compensation, as defined in the Plan Document.

Payment of benefits – Upon termination, the participants or beneficiaries may elect to leave their account balance in the Plan, receive their total benefits in a lump sum amount, a single life annuity (if participant is single), or a 50% joint and survivor annuity (if participant is married) equal to the value of the participant's interest in their account.

Stanford Health Care Retirement Savings Plan

Notes to Financial Statements

Notes receivable from participants – The Plan allows participants to borrow from \$1,000 up to the lesser of \$50,000 or 50% of their account balance. The notes receivable are secured by the participant's balance. Such notes receivable bear interest at the available market financing rates and must be repaid to the Plan within a five-year period, unless the proceeds are used for the purchase of a principal residence in which case the maximum repayment period may be longer. The specific terms and conditions of such notes receivable are established by the Committee. Outstanding notes receivable at December 31, 2024, carry interest rates ranging from 4.00% to 9.50% with maturity dates through December 2034.

NOTE 5 – CERTIFIED INVESTMENT INFORMATION

The Plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the custodians of the Plan have certified to the completeness and accuracy of:

- Investments and notes receivable reflected on the accompanying statements of net assets available for benefits as of December 31, 2024 and 2023.
- Net appreciation in fair value of investments, dividends and interest, and interest income from notes receivable, reflected on the accompanying statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023.
- Investments reflected on the schedule of assets (held at end of year) as of December 31, 2024.

NOTE 6 – PLAN TERMINATION OR MODIFICATION

SHC intends to continue the Plan indefinitely for the benefit of its participants; however, it reserves the right to terminate or modify the Plan at any time by resolution of its Board of Directors and subject to the provisions of ERISA.

**Supplemental Schedule
Required by the Department of Labor**

Stanford Health Care Retirement Savings Plan
Schedule H, Line 4(i) – Schedule of Assets (Held at End of Year)
December 31, 2024

Plan Sponsor: Stanford Health Care
Employer Identification Number: 94-6174066
Plan Number: 002
Schedule H, Line 4(i)

| (a) | (b) | (c) | (d) | (e) |
|-----|---|---|------|------------------|
| | Identity of issue, borrower, lessor, or similar party | Description of investment including maturity date, rate of interest, collateral, par, or maturity value | Cost | Current value |
| | Fidelity: | | | |
| * | Fidelity Total Market Index Fund | Registered Investment Company | *** | \$ 890,483,647 |
| * | Fidelity Freedom Index 2050 Fund | Registered Investment Company | *** | 839,373,336 |
| * | Fidelity Freedom Index 2045 Fund | Registered Investment Company | *** | 711,192,556 |
| * | Fidelity Freedom Index 2040 Fund | Registered Investment Company | *** | 662,362,298 |
| * | Fidelity Freedom Index 2035 Fund | Registered Investment Company | *** | 559,489,520 |
| | Columbia Contrarian Core Fund | Registered Investment Company | *** | 469,195,588 |
| * | Fidelity Freedom Index 2030 Fund | Registered Investment Company | *** | 421,287,860 |
| * | Fidelity Freedom Index 2055 Fund | Registered Investment Company | *** | 300,355,213 |
| * | Fidelity Freedom Index 2025 Fund | Registered Investment Company | *** | 268,143,991 |
| ** | Self-Directed Brokerage Accounts | Self-Directed Brokerage Accounts | *** | 221,695,260 |
| * | Fidelity Freedom Index 2060 Fund | Registered Investment Company | *** | 185,183,053 |
| * | Fidelity Freedom Index 2020 Fund | Registered Investment Company | *** | 126,113,006 |
| | Vanguard Treasury Money Market Fund | Registered Investment Company | *** | 121,113,126 |
| | Macquarie Small Cap Core Fund Class R6 | Registered Investment Company | *** | 114,099,205 |
| * | Fidelity Total International Index Fund | Registered Investment Company | *** | 65,796,394 |
| | NYL Guaranteed Interest Account | Guaranteed Interest Account | *** | 65,508,123 |
| | Dodge & Cox International Stock Fund Class X | Registered Investment Company | *** | 51,076,270 |
| * | Fidelity U.S. Bond Index Fund | Registered Investment Company | *** | 50,355,501 |
| | PGIM Total Return Bond Fund | Registered Investment Company | *** | 50,162,561 |
| | Participant loans | Interest rates ranging from 4.00% to 9.50% | - | 49,611,176 |
| * | Fidelity Freedom Index 2015 Fund | Registered Investment Company | *** | 43,563,450 |
| * | Fidelity Freedom Index 2065 Fund | Registered Investment Company | *** | 43,535,986 |
| * | Fidelity Freedom Index Fund | Registered Investment Company | *** | 14,142,373 |
| | Dodge & Cox Global Bond Fund | Registered Investment Company | *** | 14,032,507 |
| | PIMCO Inflation Response MultiAsset Fund | Registered Investment Company | *** | 2,561,083 |
| * | Fidelity Government Money Market Fund | Interest-bearing cash | *** | 608,022 |
| * | Fidelity Freedom Index 2070 Fund | Registered Investment Company | *** | 198,414 |
| | Teachers Insurance and Annuity Association - College Retirement Equities Fund: | | | |
| * | CREF Stock | Registered Investment Company | *** | 146,458,540 |
| * | TIAA Traditional GIC Fund (Non fully benefit-responsive) | Fixed Annuity Contract | *** | 103,950,396 |
| * | CREF Growth | Registered Investment Company | *** | 65,400,083 |
| * | CREF Money Market | Registered Investment Company | *** | 89,541,901 |
| * | CREF Equity Index | Registered Investment Company | *** | 52,433,707 |
| * | TIAA Traditional GIC Fund (Fully benefit-responsive) | Fixed Annuity Contract | *** | 44,091,891 |
| * | CREF Global Equities | Registered Investment Company | *** | 36,922,195 |
| * | CREF Social Choice | Registered Investment Company | *** | 17,156,493 |
| * | TIAA Real Estate | Pooled Separate Account | *** | 9,014,657 |
| * | CREF Core Bond | Registered Investment Company | *** | 8,652,592 |
| * | CREF Inflation-Linked Bond | Registered Investment Company | *** | 4,969,661 |

Stanford Health Care Retirement Savings Plan
Schedule H, Line 4(i) – Schedule of Assets (Held at End of Year) (continued)
December 31, 2024

Plan Sponsor: Stanford Health Care
Employer Identification Number: 94-6174066
Plan Number: 002
Schedule H, Line 4(i)

| (a) | (b) | (c) | (d) | (e) |
|-----|--|---|------|-------------------------|
| | Identity of issue, borrower, lessor, or similar party | Description of investment including maturity date, rate of interest, collateral, par, or maturity value | Cost | Current value |
| | Empower Annuity Insurance Company: | | | |
| * | Guaranteed Interest Account | Guaranteed Interest Account | *** | 746,244 |
| * | Medley Prudential Capital Growth Account | Pooled Separate Account | *** | 110,714 |
| * | Medley PSF PGIM Flexible Managed Portfolio | Pooled Separate Account | *** | 66,431 |
| * | Medley PSF Global Portfolio | Pooled Separate Account | *** | 66,193 |
| * | Medley PSF PGIM Jennison Blend Portfolio | Pooled Separate Account | *** | 30,514 |
| * | Medley PSF Stock Index Portfolio | Pooled Separate Account | *** | 6,001 |
| * | Medley PSF PGIM 50/50 Balanced Portfolio | Pooled Separate Account | *** | 3,784 |
| * | Medley PSF PGIM Government Money Market Portfolio | Pooled Separate Account | *** | 1,946 |
| * | Medley PSF PGIM Total Return Bond Portfolio | Pooled Separate Account | *** | 1,092 |
| | Lincoln National Life Insurance Company: | | | |
| * | Fixed Account | Guaranteed Income Account | *** | 70,672 |
| | | | | <u>\$ 6,920,935,226</u> |

* Party-in-interest
** Includes parties-in-interest
*** Information is not required as investments are participant directed

Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms.

Stanford Health Care Retirement Savings Plan
Schedule H, Line 4(i) – Schedule of Assets (Held at End of Year)
December 31, 2024

Plan Sponsor: Stanford Health Care
Employer Identification Number: 94-6174066
Plan Number: 002
Schedule H, Line 4(i)

| (a) | (b) | (c) | (d) | (e) |
|-----|---|---|------|------------------|
| | Identity of issue, borrower, lessor, or similar party | Description of investment including maturity date, rate of interest, collateral, par, or maturity value | Cost | Current value |
| | Fidelity: | | | |
| * | Fidelity Total Market Index Fund | Registered Investment Company | *** | \$ 890,483,647 |
| * | Fidelity Freedom Index 2050 Fund | Registered Investment Company | *** | 839,373,336 |
| * | Fidelity Freedom Index 2045 Fund | Registered Investment Company | *** | 711,192,556 |
| * | Fidelity Freedom Index 2040 Fund | Registered Investment Company | *** | 662,362,298 |
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| * | CREF Equity Index | Registered Investment Company | *** | 52,433,707 |
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| * | CREF Global Equities | Registered Investment Company | *** | 36,922,195 |
| * | CREF Social Choice | Registered Investment Company | *** | 17,156,493 |
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| * | CREF Core Bond | Registered Investment Company | *** | 8,652,592 |
| * | CREF Inflation-Linked Bond | Registered Investment Company | *** | 4,969,661 |

Stanford Health Care Retirement Savings Plan
Schedule H, Line 4(i) – Schedule of Assets (Held at End of Year) (continued)
December 31, 2024

Plan Sponsor: Stanford Health Care
Employer Identification Number: 94-6174066
Plan Number: 002
Schedule H, Line 4(i)

| (a) | (b) | (c) | (d) | (e) |
|-----|--|---|------|-------------------------|
| | Identity of issue, borrower, lessor, or similar party | Description of investment including maturity date, rate of interest, collateral, par, or maturity value | Cost | Current value |
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| * | Guaranteed Interest Account | Guaranteed Interest Account | *** | 746,244 |
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| * | Medley PSF PGIM Jennison Blend Portfolio | Pooled Separate Account | *** | 30,514 |
| * | Medley PSF Stock Index Portfolio | Pooled Separate Account | *** | 6,001 |
| * | Medley PSF PGIM 50/50 Balanced Portfolio | Pooled Separate Account | *** | 3,784 |
| * | Medley PSF PGIM Government Money Market Portfolio | Pooled Separate Account | *** | 1,946 |
| * | Medley PSF PGIM Total Return Bond Portfolio | Pooled Separate Account | *** | 1,092 |
| | Lincoln National Life Insurance Company: | | | |
| * | Fixed Account | Guaranteed Income Account | *** | 70,672 |
| | | | | <u>\$ 6,920,935,226</u> |

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