

<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: x-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 style="text-align: center;">▶ 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; text-align: center;">2024</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>BELOIT HEALTH SYSTEM 403(B) 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>BELOIT HEALTH SYSTEM, INC.</u></p> <p><u>1969 WEST HART ROAD</u> <u>BELOIT, WI 53511-2230</u></p>	<p>1c Effective date of plan <u>01/01/2009</u></p> <p>2b Employer Identification Number (EIN) <u>39-1028081</u></p> <p>2c Plan Sponsor's telephone number <u>608-364-5171</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.	10/14/2025	THOMAS J. MCCAWLEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1851
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1639
	6a(2)	1596
	6b	4
	6c	227
	6d	1827
	6e	3
	6f	1830
	6g(1)	1113
6g(2)	1182	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2E 2M 2R 3D

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

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<p>A Name of plan BELOIT HEALTH SYSTEM 403(B) 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 BELOIT HEALTH SYSTEM, INC.</p>	<p>D Employer Identification Number (EIN) 39-1028081</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
AXA EQUITABLE LIFE INSURANCE CO.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	760891	39	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	1545776
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	2332226

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 ▶ **GUARANTEED INTEREST OPTION**

b Balance at the end of the previous year	7b	1549871
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c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	43056
	7c(4)	
	7c(5)	

(6) Total additions	7c(6)	43056
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d Total of balance and additions (add lines 7b and 7c(6))	7d	1592927
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e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	40505
	7e(2)	203
	7e(3)	6443
	7e(4)	

(5) Total deductions	7e(5)	47151
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f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	1545776
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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.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan BELOIT HEALTH SYSTEM 403(B) PLAN	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 BELOIT HEALTH SYSTEM, INC.	D Employer Identification Number (EIN) 39-1028081	

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

AXA EQUITABLE LIFE INSURANCE CO.

13-5570651

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

FID INV INST OPS CO

04-2647786

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

INVESCO CAPITAL MANAGEMENT

58-1707262

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

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

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

FID INV INST OPS CO

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?
15 37 50 64 65 71 26	RECORDKEEPER	165696	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)

STRATEGIC ADVISORS

04-2654524

(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?
26 50	INV. ADVISORY	20157	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
AQR INTERNATIONAL MOMENTUM STYLE CL 1 GREENWICH PLAZA GREENWICH, CT 06830	0.40%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
AQR SMALL CAP MOMENTUM STYLE CL N 1 GREENWICH PLAZA GREENWICH, CT 06830	0.40%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
AQR LARGE CAP MOMENTUM STYLE CL N 1 GREENWICH PLAZA GREENWICH, CT 06830	0.40%	

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
FID INV INSTL OPS CO	60	0
(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.	
AQR SMALL CAP MOMENTUM STYLE CL I 1 GREENWICH PLAZA GREENWICH, CT 06830	0.12%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
GQG PARTNERS US QUALITY SEL EQ INST 1 FREEDOM VALLEY DR OAKS, PA 19456	0.15%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
GQG PARTNERS US QULTSELECT EQUITY I 1 FREEDOM VALLEY DR OAKS, PA 19456	0.40%	

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
FID INV INSTL OPS CO	60	0
(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.	
ASHMORE EMERG MRKTS EQUITY FD CL A 801 S CANAL ST CHICAGO, IL 60607	0.08%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
AXONIC STRATEGIC INCOME FUND A 520 MADISON AVE 42ND FL NEW YORK, NY 10022	0.10%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
BNY MELLON GLOBAL FIXED INCOME I 144 GLENN CURTISS BLVD UNIONDALE, NY 11556	0.15%	

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
FID INV INSTL OPS CO	60	0
(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.	
BNY MELLON GLOBAL FIXED INCOME A 144 GLENN CURTISS BLVD UNIONDALE, NY 11556	0.40%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
FULLERTHALER BEHV SMALL CAP EQTY 411 BOREL AVE STE 300 IN SAN MATEO, CA 94402	0.40%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
SEAFARER OVERSEAS GROWTH & INCOME I 1290 BROADWAY STE 1100 DENVER, CO 80203	0.40%	

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
FID INV INSTL OPS CO	60	0
(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.	
ALPS SMITH SHORT DURATION BOND CL I 1290 BROADWAY STE 1100 DENVER, CO 80203	0.15%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
FRANKLIN INCOME CL A 100 FOUNTAIN PARKWAY ST. PETERSBURG, FL 33716	\$16.00	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
GOLDMAN SACHS GQG PARTNERS INTL OPP 71 S WACKER DR 4TH FL CHICAGO, IL 60606	0.17%	

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
FID INV INSTL OPS CO	60	0
(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.
GUGGENHEIM TOTAL RETURN BOND FD INS 9601 BLACKWELL RD STE 500 ROCKVILLE, MD 20850		0.15%
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.
HARTFORD INTL VALUE FD CLASS I 100 MATSONFORD RD RADNOR, PA 19087		0.15%
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.
HARTFORD INTL VALUE FD CLASS A 100 MATSONFORD RD RADNOR, PA 19087		0.40%

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
FID INV INSTL OPS CO	60	0
(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.	
HOTCHKIS & WILEY SML CAP DIVE VALUE 725 S FIGUEROA LOS ANGELES, CA 90017	0.40%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
SGI SMALL CAP GROWTH FUND INSTL 2310 WASHINGTON ST NEWTON, MA 02462	0.10%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
SGI GLOBAL EQUITY FUND CL I 1055 WESTLAKES DR BERWYN, PA 19312	0.40%	

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
FID INV INSTL OPS CO	60	0
(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.	
SGI US LARGE CAP EQUITY FD CL I 620 S MAIN ST BOUNTIFUL, UT 84010	0.10%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
T ROWE PRICE DIVIDEND GROWTH 4515 PAINTERS MILL RD OWINGS MILLS, MD 21117	0.15%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
BAIRD AGGR BOND INST 39-0281260	0.02%	

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
FID INV INSTL OPS CO	60	0
(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.	
DODGE & COX INTL STK I 1345 AVENUE OF THE AMERICAS NEW YORK, NY 10105	0.10%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FID INV INSTL OPS CO	60	0
(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.	
DODGE & COX STK I 1345 AVENUE OF THE AMERICAS NEW YORK, NY 10105	0.10%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 <hr/> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>BELOIT HEALTH SYSTEM 403(B) 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>BELOIT HEALTH SYSTEM, INC.</u>	D Employer Identification Number (EIN) <u>39-1028081</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)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA AGGRESSIVE ALLOCATION</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570651-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>43122</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA INT VAL MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570652-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>28393</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA LG CAP CORE MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570653-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>20325</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA LG CAP GRW MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570654-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>131841</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA LG CAP VAL MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570655-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>151872</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA GLB EQTY MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570656-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>44979</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>AXA MID CAP VAL MANAGED VOL</u>		
b Name of sponsor of entity listed in (a): <u>AXA EQUITABLE LIFE INSURANCE COMPANY</u>		
c EIN-PN <u>13-5570657-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>170193</u>

a Name of MTIA, CCT, PSA, or 103-12 IE: AXA MODERATE-PLUS ALLOCATION		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570658-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 56014
a Name of MTIA, CCT, PSA, or 103-12 IE: AXA MODERATE ALLOCATION		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570659-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 269140
a Name of MTIA, CCT, PSA, or 103-12 IE: AXA/AB SMALL CAP GROWTH		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570660-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 82551
a Name of MTIA, CCT, PSA, or 103-12 IE: AXA/HORIZON SMALL CAP VALUE		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570661-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12372
a Name of MTIA, CCT, PSA, or 103-12 IE: CHARTER MULTI-SECTOR BOND		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570662-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 31708
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/BLACKROCK BASIC VALUE EQTY		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570663-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 24129
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/CAPITAL GUARDIAN RESEARCH		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570664-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 17373
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/COM STOCK INDEX		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570665-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 209113
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/EQUITY 500 INDEX		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570666-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 397918
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/GAMCO SMALL COMPANY VALUE		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 97443

a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/INTERMEDIATE GOVERNMENT BND		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1917
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/INTERNATIONAL EQUITY INDEX		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 70528
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/INVESCO COMSTOCK		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/JP MORGAN GROWTH STOCK		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 92304
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/JP MORGAN VALUE OPPORTUNITIES		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12959
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/LARGE CAP GROWTH INDEX		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 125545
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MFS INTERNATIONAL GROWTH		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 14913
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MFS INTERNATIONAL VALUE		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 13430
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MFS TECHNOLOGY		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 165
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MFS UTILITIES SERIES		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 84

a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MID CAP INDEX		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/OPPENHEIMER GLOBAL		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 120
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/QUALITY BOND PLUS		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 18278
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/WELLINGTON ENERGY		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0
a Name of MTIA, CCT, PSA, or 103-12 IE: FIDELITY VIP MID CAP		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 235
a Name of MTIA, CCT, PSA, or 103-12 IE: MULTIMANAGER AGGRESSIVE EQUITY		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 22442
a Name of MTIA, CCT, PSA, or 103-12 IE: RUSSELL 2000 5YR - 20% BUFFER		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 357
a Name of MTIA, CCT, PSA, or 103-12 IE: S&P 500 INDEX 1YR - 10% BUFFER		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 68
a Name of MTIA, CCT, PSA, or 103-12 IE: S&P 500 INDEX 5YR - 20% BUFFER		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 125998
a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/ PIMCO ULTRA SHORT BOND		
b Name of sponsor of entity listed in (a): AXA EQUITABLE LIFE INSURANCE COMPANY		
c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12457

a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/MFS MID CAP FOCUSED GROWTH

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

c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 6272
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a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/AMER CENTURY MID CAP VAL

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

c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 6273
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a Name of MTIA, CCT, PSA, or 103-12 IE: EQ/PRINCIPAL VC EQUITY INCOME

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

c EIN-PN 13-5570667-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 19373
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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)
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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
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan BELOIT HEALTH SYSTEM 403(B) PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 BELOIT HEALTH SYSTEM, INC.	D Employer Identification Number (EIN) 39-1028081

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)	
(2) Participant contributions	1b(2)	
(3) Other	1b(3)	
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	11662789
(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)	564072
(9) Value of interest in common/collective trusts	1c(9)	
(10) Value of interest in pooled separate accounts	1c(10)	2332226
(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)	102177469
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	1545776
(15) Other.....	1c(15)	

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	106201600	118282332
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	106201600	118282332

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)		
(B) Participants.....	2a(1)(B)	7140295	
(C) Others (including rollovers).....	2a(1)(C)	814497	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		7954792
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	522430	
(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)	52876	
(F) Other.....	2b(1)(F)	43056	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		618362
(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)	4044898	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		4044898
(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)		0
(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)		0

		(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)		
(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)		8922396
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		21540448

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	9272644	
(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)		9272644
f Corrective distributions (see instructions)	2f		289
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)	52540	
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	132383	
(6) Bank or trust company trustee/custodial fees	2i(6)	1860	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		186783
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		9459716

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		12080732
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: **WIPFLI CPAS AND CONSULTANTS**

(2) EIN: **39-0758449**

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		2000000
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.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>BELOIT HEALTH SYSTEM 403(B) 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>BELOIT HEALTH SYSTEM, INC.</u>	D Employer Identification Number (EIN) <u>39-1028081</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
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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): 04-6568107 13-5570651

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

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

3	
---	--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part VII IRS Compliance Questions

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

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

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 08 / 07 / 2017 (MM/DD/YYYY) and the Opinion Letter serial number J500955A.

Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, and Par or Maturity Value	(d) Cost	(e) Current Value
	* Self-directed brokerage accounts		** \$	8,615,545
Mutual funds:				
	American Beacon	Small Cap Value Fund	**	166,108
	American Funds	EuroPacific Growth Fund	**	1,188,785
	Baird	Aggregate Bond Fund	**	3,954,647
	Dodge & Cox	International Stock Fund	**	1,089,717
	Dodge & Cox	Stock Fund	**	2,474,112
	* Fidelity	Government Cash Reserves	**	11,291,973
	* Fidelity	Growth Strategies K6 Fund	**	533,461
	MFS	Mid Cap Value Fund	**	1,548,549
	Vanguard	Explorer Fund	**	1,741,755
	Vanguard	Institutional Index Fund	**	1,423,422
	Vanguard	Mid Cap Index Fund	**	566,543
	Vanguard	Prime Cap Fund	**	10,528,926
	Vanguard	Real Estate Index Fund	**	564,058
	Vanguard	Small Cap Index Fund	**	2,739,832
	Vanguard	Target Retirement 2020 Fund	**	823,181
	Vanguard	Target Retirement 2025 Fund	**	4,555,500
	Vanguard	Target Retirement 2030 Fund	**	6,048,149
	Vanguard	Target Retirement 2035 Fund	**	8,785,149
	Vanguard	Target Retirement 2040 Fund	**	3,905,063
	Vanguard	Target Retirement 2045 Fund	**	3,693,533
	Vanguard	Target Retirement 2050 Fund	**	3,526,546
	Vanguard	Target Retirement 2055 Fund	**	2,355,755
	Vanguard	Target Retirement 2060 Fund	**	1,022,384
	Vanguard	Target Retirement 2065 Fund	**	426,810
	Vanguard	Target Retirement Income Fund	**	47,737
	Vanguard	Institutional Index Fund	**	20,090,030
	Vanguard	Wellington Fund	**	6,508,054
	Wells Fargo	Emerging Markets Equity Fund	**	1,404,649
	* OppenheimerFunds	Active Allocation Fund A	**	846,469
	* OppenheimerFunds	Active Allocation Fund C	**	135,778
	* OppenheimerFunds	Active Allocation Fund R	**	37,516
	* OppenheimerFunds	Conservative Investor Fund A	**	169,423
	* OppenheimerFunds	Conservative Investor Fund C	**	6,999
	* OppenheimerFunds	Conservative Investor Fund R	**	321,914
	* OppenheimerFunds	Dividend Income Fund R	**	34,022

Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

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Mutual funds: (continued)				
*	OppenheimerFunds	Global Allocation Fund A	**	\$ 689
*	OppenheimerFunds	Global Opportunities Fund R	**	1,878
*	OppenheimerFunds	Growth Investor Fund A	**	65,720
*	OppenheimerFunds	Growth Investor Fund C	**	142,165
*	OppenheimerFunds	Main Street Fund R	**	18,012
*	OppenheimerFunds	Moderate Investor Fund A	**	274,726
*	OppenheimerFunds	Moderate Investor Fund C	**	31,363
*	OppenheimerFunds	Moderate Investor Fund R	**	132,771
*	OppenheimerFunds	Multi-Asset Income Fund A	**	839
Pooled separate accounts:				
*	Equitable Financial	Aggressive Allocation	**	43,121
*	Equitable Financial	American Century Mid Cap Value	**	6,273
*	Equitable Financial	Blackrock Basic Value Equity	**	24,129
*	Equitable Financial	Capital Guardian Research	**	17,373
*	Equitable Financial	Charter Multi-Sector Bond	**	31,708
*	Equitable Financial	Com Stock Index	**	209,113
*	Equitable Financial	Equity 500 Index	**	397,918
*	Equitable Financial	Fidelity VIP Mid Cap	**	235
*	Equitable Financial	GAMCO Small Company Value	**	97,443
*	Equitable Financial	Global Equity Managed Volatility	**	44,979
*	Equitable Financial	HLD Acct Russel 2000 5 yr - 20% Buffer	**	357
*	Equitable Financial	Horizon Small Cap Value	**	12,372
*	Equitable Financial	Int Gov Bond Index	**	1,917
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*	Equitable Financial	International Value Managed Volatility	**	28,393
*	Equitable Financial	Invesco Comstock	**	11
*	Equitable Financial	JP Morgan Growth Stock	**	92,304
*	Equitable Financial	JP Morgan Value Opportunities	**	12,959
*	Equitable Financial	Large Cap Core Managed Volatility	**	20,325
*	Equitable Financial	Large Cap Growth Index	**	125,545
*	Equitable Financial	Large Cap Growth Managed Volatility	**	131,841
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*	Equitable Financial	MFS Mid Cap FOC Used Growth	**	6,272
*	Equitable Financial	MFS Technology	**	167
*	Equitable Financial	MFS Utilities Series	**	84
*	Equitable Financial	Mid Cap Index	**	11
*	Equitable Financial	Mid Cap Value Manage Volatility	**	170,193

Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, and Par or Maturity Value	(d) Cost	(e) Current Value
Pooled separate accounts (continued):				
*	Equitable Financial	Moderate Allocation	**	\$ 269,141
*	Equitable Financial	Moderate-Plus Allocation	**	56,014
*	Equitable Financial	Multimanager Aggressive Equity	**	22,442
*	Equitable Financial	Oppenheimer Global	**	120
*	Equitable Financial	PIMCO Ultra Short Bond	**	12,457
*	Equitable Financial	Principal VC Equity Income	**	19,373
*	Equitable Financial	Quality Bond Plus	**	18,278
*	Equitable Financial	SIO - S&P 500 Index 1yr - 10% Buffer	**	67
*	Equitable Financial	SIO S&P 500 Index 5yr - 20% Buffer	**	125,998
*	Equitable Financial	Small Cap Growth	**	82,551
Total investments at fair value				\$ 116,172,484
*	Equitable Financial	Guaranteed Interest Account	**	\$ 1,545,776
*	Participant loans	***	\$0	\$ 564,072

* Denotes party-in-interest.

** Information not required for participant-directed investments.

*** Participant loans have interest rates ranging from 3.25% to 10.50% with payments through November 2033

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Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, and Par or Maturity Value	(d) Cost	(e) Current Value
	* Self-directed brokerage accounts		** \$	8,615,545
Mutual funds:				
	American Beacon	Small Cap Value Fund	**	166,108
	American Funds	EuroPacific Growth Fund	**	1,188,785
	Baird	Aggregate Bond Fund	**	3,954,647
	Dodge & Cox	International Stock Fund	**	1,089,717
	Dodge & Cox	Stock Fund	**	2,474,112
	* Fidelity	Government Cash Reserves	**	11,291,973
	* Fidelity	Growth Strategies K6 Fund	**	533,461
	MFS	Mid Cap Value Fund	**	1,548,549
	Vanguard	Explorer Fund	**	1,741,755
	Vanguard	Institutional Index Fund	**	1,423,422
	Vanguard	Mid Cap Index Fund	**	566,543
	Vanguard	Prime Cap Fund	**	10,528,926
	Vanguard	Real Estate Index Fund	**	564,058
	Vanguard	Small Cap Index Fund	**	2,739,832
	Vanguard	Target Retirement 2020 Fund	**	823,181
	Vanguard	Target Retirement 2025 Fund	**	4,555,500
	Vanguard	Target Retirement 2030 Fund	**	6,048,149
	Vanguard	Target Retirement 2035 Fund	**	8,785,149
	Vanguard	Target Retirement 2040 Fund	**	3,905,063
	Vanguard	Target Retirement 2045 Fund	**	3,693,533
	Vanguard	Target Retirement 2050 Fund	**	3,526,546
	Vanguard	Target Retirement 2055 Fund	**	2,355,755
	Vanguard	Target Retirement 2060 Fund	**	1,022,384
	Vanguard	Target Retirement 2065 Fund	**	426,810
	Vanguard	Target Retirement Income Fund	**	47,737
	Vanguard	Institutional Index Fund	**	20,090,030
	Vanguard	Wellington Fund	**	6,508,054
	Wells Fargo	Emerging Markets Equity Fund	**	1,404,649
	* OppenheimerFunds	Active Allocation Fund A	**	846,469
	* OppenheimerFunds	Active Allocation Fund C	**	135,778
	* OppenheimerFunds	Active Allocation Fund R	**	37,516
	* OppenheimerFunds	Conservative Investor Fund A	**	169,423
	* OppenheimerFunds	Conservative Investor Fund C	**	6,999
	* OppenheimerFunds	Conservative Investor Fund R	**	321,914
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Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, and Par or Maturity Value	(d) Cost	(e) Current Value
Mutual funds: (continued)				
*	OppenheimerFunds	Global Allocation Fund A	**	\$ 689
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*	OppenheimerFunds	Growth Investor Fund A	**	65,720
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*	OppenheimerFunds	Moderate Investor Fund A	**	274,726
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*	OppenheimerFunds	Moderate Investor Fund R	**	132,771
*	OppenheimerFunds	Multi-Asset Income Fund A	**	839
Pooled separate accounts:				
*	Equitable Financial	Aggressive Allocation	**	43,121
*	Equitable Financial	American Century Mid Cap Value	**	6,273
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Beloit Health System 403(b) Plan

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

EIN #39-1028081 Plan #002

December 31, 2024

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Beloit Health System 403(b) Plan

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

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