

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor HPMPPT BOARD OF TRUSTEES PO BOX 9406 MISSOULA, MT 59807	3b Administrator's EIN 71-1029753 3c Administrator's telephone number 406-443-4919
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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
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5 Total number of participants at the beginning of the plan year	5	1310
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6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
6a(1) Total number of active participants at the beginning of the plan year	6a(1) 1301
6a(2) Total number of active participants at the end of the plan year	6a(2) 1297
b Retired or separated participants receiving benefits	6b 8
c Other retired or separated participants entitled to future benefits	6c 2
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 1307
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e
f Total. Add lines 6d and 6e	6f
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h

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

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

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

a Pension Schedules

(1) **R** (Retirement Plan Information)

(2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(4) **DCG** (Individual Plan Information) – Number Attached _____

(5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

(1) **H** (Financial Information)

(2) **I** (Financial Information – Small Plan)

(3) **A** (Insurance Information) – Number Attached 2

(4) **C** (Service Provider Information)

(5) **D** (DFE/Participating Plan Information)

(6) **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code 164953278

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan HEALTH PROFESSIONS OF MONTANA PLAN & TRUST		B Three-digit plan number (PN) ▶ 550
C Plan sponsor's name as shown on line 2a of Form 5500 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST		D Employer Identification Number (EIN) 45-2078503

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
STANDARD INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	170285	1299	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 0	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) 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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	27819	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	-1891	
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3))	9a(4)		25928
b	Benefit charges (1) Claims paid	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)	615	
	(3) Incurred claims (add (1) and (2))	9b(3)		615
	(4) Claims charged	9b(4)		615
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)	3539	
	(E) Taxes	9c(1)(E)	713	
	(F) Charges for risks or other contingencies	9c(1)(F)	2035	
	(G) Other retention charges	9c(1)(G)	17143	
	(H) Total retention	9c(1)(H)		23430
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
	(2) Claim reserves	9d(2)		
	(3) Other reserves	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

<p 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: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan HEALTH PROFESSIONS OF MONTANA PLAN & TRUST</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>550</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST</p>	<p>D Employer Identification Number (EIN) 45-2078503</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
HCC LIFE INSURANCE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-1817054	92711	HCL34782	1373	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">147211</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

ALLIANT INSURANCE SERVICES, INC. **818 WEST RIVERSIDE, SUITE 800**
SPOKANE, WA 99201

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
98513			3

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

BENEFIT ADVISORS SERVICES GROUP, LLC **PO BOX 675236**
DETROIT, MI 48267-5236

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
48699			3

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	985128
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST	B Three-digit plan number (PN) ▶	550
C Plan sponsor's name as shown on line 2a of Form 5500 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST	D Employer Identification Number (EIN) 45-2078503	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

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

BLUE CROSS BLUE SHIELD OF MONTANA

PO BOX 4309
HELENA, MT 59604

81-0216685

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	PLAN ADMINISTRATOR S	624019	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)

HPMPT SPONSOR ORG INC.

PO BOX 9406
MISSOULA, MT 59807

45-2078503

(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?
49	PLAN SPONSOR	391596	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)

LEIF ASSOCIATES, INC

1331 17TH ST 350
DENVER, CO 80202

84-1324324

(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?
	ACTUARY AND UNDERWRITING	175180	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

ALLIANT INSURANCE SERVICES INC

818 WEST RIVERSIDE SUITE 800
SPOKANE, WA 99201

33-0785439

(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?
70	CONSULTANT	73517	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)

LARSEN LAW, PLLC

24551 BENHAVEN LANE
MIDDLETON, ID 83644

27-3524884

(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?
29	ATTORNEY	61256	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)

EIDE BAILLY LLP

4310 17TH AVE S PO BOX 2545
FARGO, ND 58108-2545

45-0250958

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	AUDITORS	31928	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

J. BRUCE ROBERTSON

935 HIGHLAND BLVD STE 216
BOZEMAN, MT 59715

(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?
20	INDEPENDENT FIDUCIARY	18000	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)

US BANK

1555 N. RIVERCENTER DR
MILWAUKEE, WI 53212

31-0841368

(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?
21	NONE	11846	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
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 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 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST	B Three-digit plan number (PN) ▶ 550
C Plan sponsor's name as shown on line 2a of Form 5500 HEALTH PROFESSIONS OF MONTANA PLAN & TRUST	D Employer Identification Number (EIN) 45-2078503

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

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1094775	1540447
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	339207	52160
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1665037	1745769
(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)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	2337921	2490292
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(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	5436940	5828668
Liabilities			
g Benefit claims payable.....	1g	1340891	2067000
h Operating payables.....	1h	32259	45352
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	68947	105049
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	1442097	2217401
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	3994843	3611267

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)	15411092	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		15411092
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	150350	
(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)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		150350
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)	85316	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		85316
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(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)		74047
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		15720805

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	13604258	
(2) To insurance carriers for the provision of benefits	2e(2)	1011047	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		14615305
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1186042	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	31928	
(5) Investment advisory and investment management fees	2i(5)	11846	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	85500	
(8) Legal fees	2i(8)	60000	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	113760	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1489076
j Total expenses. Add all expense amounts in column (b) and enter total	2j		16104381

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-383576
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: EIDE BAILLY LLP

(2) EIN: 45-0250958

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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 _____.

Financial Statements
December 31, 2024 and 2023
**Health Professions of Montana
Plan and Trust**

Health Professions of Montana Plan and Trust

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December 31, 2024 and 2023

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CPAs & BUSINESS ADVISORS

Independent Auditor's Report

The Board of Trustees of
Health Professions of Montana Plan and Trust
Helena, Montana

Opinion

We have audited the financial statements of Health Professions of Montana Plan and Trust (the Plan), an employee benefit plan subject to the Employee Retirement Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the year ended December 31, 2024, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of the Plan as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and plan benefit obligations for the year ended December 31, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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401 N. 31st St., Ste. 1120 | P.O. Box 7112 | Billings, MT 59103-7112 | TF 800.824.9797 | T 406.896.2400 | F 406.252.8600 | EOE

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule H, line 4i – schedule of assets held at end of year, and schedule H, line 4j – schedule of reportable transactions as of or for the year ended December 31, 2024, are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

Additional Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of administrative expenses for the year ended December 31, 2024, is also presented for the purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

The image shows a handwritten signature in black ink that reads "Eide Bailly LLP". The signature is written in a cursive, flowing style.

Billings, Montana
September 25, 2025

Health Professions of Montana Plan and Trust
Statements of Net Assets Available for Benefits
December 31, 2024 and 2023

	2024	2023
Assets		
Investments, at fair value	\$ 4,236,061	\$ 4,002,958
Receivables		
Accounts receivable	4,800	-
Estimated pharmacy rebate	21,321	188,674
Estimated stop loss recovery	6,509	109,014
Income tax	156	-
Total receivables	32,786	297,688
Cash	1,540,447	1,094,775
Net deferred tax asset	15,682	37,682
Prepaid expenses	3,562	3,679
Accrued income	130	158
Total assets	5,828,668	5,436,940
Liabilities		
Accounts payable	45,352	32,259
Unearned employer contributions	105,049	5,703
Income tax payable	-	63,244
Total liabilities	150,401	101,206
Net Assets Available for Benefits	\$ 5,678,267	\$ 5,335,734

Health Professions of Montana Plan and Trust
Statement of Changes in Net Assets Available for Benefits
Year Ended December 31, 2024

Additions	
Contributions	\$ 15,236,682
Limited continuation of coverage contributions	<u>174,410</u>
Total contributions	<u>15,411,092</u>
Investment income	
Interest and dividends	235,666
Net appreciation in fair value of investments	<u>74,047</u>
	309,713
Less investment expenses	<u>(11,846)</u>
Total investment income	<u>297,867</u>
Total additions	<u>15,708,959</u>
Deductions	
Payments for benefits	
Health claims	12,878,149
Premiums paid to insurance companies	<u>1,011,047</u>
Total benefits paid	13,889,196
Income tax expense	<u>101,000</u>
Administrative expenses	<u>1,376,230</u>
Total deductions	<u>15,366,426</u>
Net increase	342,533
Net Assets Available for Benefits	
Beginning of year	<u>5,335,734</u>
End of year	<u><u>\$ 5,678,267</u></u>

Health Professions of Montana Plan and Trust
 Statements of Benefit Obligations
 December 31, 2024 and 2023

	2024	2023
Amounts Currently Payable		
Claims payable and claims incurred but not reported	\$ 1,910,000	\$ 1,188,891
Unpaid claims administration expenses	157,000	152,000
Total Benefit Obligations	\$ 2,067,000	\$ 1,340,891
Net Assets Available for Benefits	\$ 5,678,267	\$ 5,335,734
Total Benefit Obligations	(2,067,000)	(1,340,891)
Excess of Net Assets Available for Benefits over Benefit Obligations	\$ 3,611,267	\$ 3,994,843

Health Professions of Montana Plan and Trust
Statement of Changes in Benefit Obligations
Year Ended December 31, 2024

Amounts Currently Payable	
Balance at beginning of year	\$ 1,340,891
Claims reported and approved for payment, including benefits reclassified from benefit obligations	13,604,258
Claims paid	<u>(12,878,149)</u>
Total Benefit Obligations at End of Year	<u>\$ 2,067,000</u>

Note 1 - Description of Plan

The following brief description of the Health Professions of Montana Plan and Trust (the Plan/Trust), formerly known as Montana Medical Association Health Care Plan and Trust, is provided for general information purposes only. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The Plan provides health benefits covering all eligible employees and dependents of participating employers in the healthcare industry in Montana. In general, a participating employer must employ at least one employee and enroll at least two eligible individuals on the Plan, cover at least 75% of eligible employees, and have its principal place of business in Montana. Employers may voluntarily subscribe to the Trust and adopt the Plan by entering into a Subscriber Agreement with the Trust and completing an Adoption Agreement. Upon execution of the Subscriber Agreement and remittance of the first required payment, the employer shall be bound by the terms and conditions of the Subscriber Agreement, the Trust Agreement, and the Self-Funded Health Benefits Policy (the "Plan Document").

The Plan and related Trust were established May 1, 2008, and the Plan is subject to the provision of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits

The Plan provides health and welfare benefits (medical, dental, vision, and prescription) by self-funding which is re-insured with individual and aggregate stop-loss insurance coverage. Employees of participating healthcare providers are eligible for benefits after satisfying the waiting period and the minimum hour requirements. The Plan provides continuation of coverage for health benefits for eligible groups as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Plan currently offers several "Medical Benefit Plan Options", ranging from comprehensive to basic coverage, and including options that are "high deductible health plans" compatible with individual Health Savings Accounts ("HSAs").

Active employees enrolled in the high-deductible health plan (HDHP) are eligible to enroll in a health savings account (HSA), subject to Internal Revenue Service (IRS) eligibility requirements. HSAs must be separately established by individual participants and are not offered or funded through the Plan. The contributions made to the HSA can be used on a tax-free basis to pay or reimburse for qualifying health care expenses. The participant owns the account and is responsible for substantiating distributions from the HSA account. HSAs are not considered Plan assets as they belong to the individual participants; therefore, there is no reporting in the accompanying financial statements as there is no obligation of the Plan to pay the benefits.

Stop Loss Coverage

Pursuant to the Trust Agreement, the Trust has maintained stop loss insurance to ensure adequate reserves and funding in accordance with statute. The Plan absorbs claims for any covered participant up to \$275,000 for the policy periods May 1, 2023, through April 30, 2025, and \$240,000 for the policy period May 1, 2022, through April 30, 2023. Claims in excess of \$275,000 for the policy periods May 1, 2023, through April 30, 2025, and \$240,000 for the policy period May 1, 2022, through April 30, 2023, for medical and standalone prescription drug program, will be covered by the excess loss insurance. The maximum specific benefit for the policy periods ended April 30, 2025, 2024 and 2023, is unlimited.

The insurance policy includes aggregate excess loss insurance coverage that has a maximum aggregate benefit of \$1,000,000 for losses that exceed the annual aggregate deductible for the policy periods ended April 30, 2025, 2024 and 2023.

The minimum annual aggregate deductible for the policy periods are as follows: May 31, 2024 through April 30, 2025; \$18,407,361, May 1, 2023, through April 30, 2024; \$15,203,451, and May 1, 2022, through April 30, 2023; \$14,694,804.

Self-Insured Benefits

The Plan is self-insured for medical, dental, vision, and prescription benefits up to individual and aggregate stop loss limits. The claims for self-insured benefits are processed by the Plan's third-party claims administrators under administrative services only (ASO) arrangements in which they adjudicate and pay claims with Plan funds. Despite the Plan's utilization of third-party claims administrators, ultimate responsibility for payments to providers and participants is retained by the Plan.

The Plan utilizes a pharmacy benefit manager (PBM) which pays rebates to the Plan based on the greater of actual rebates, guaranteed rebates, or a contracted rate per employee.

Eligibility

In general, an eligible employee must work for a participating employer on a continuing and regular basis for a minimum of 80 to 160 hours per month depending on the options selected. If both spouses are employees of the same participating employer, and both are eligible for dependent coverage, either spouse, but not both, may elect dependent coverage. In addition, an employee must be actively working for a participating employer on the first day of the month containing the effective date of coverage, unless absent due to a health factor.

Contributions

Monthly trust contributions (or "premiums") are made by participating employers and may be funded partly by employer contributions or salary reductions from a participating employer's covered participants. Participating employers determine what portion of the premiums must be paid by the employer and what portion paid by the covered participants. However, the participating employer must pay at least 50% of the employee premium. Any premiums paid through salary reductions of participating employer's covered participants are included in contributions in the statement of changes in net assets available for benefits.

Participating employers also are required to pay a service fee which is based on a per employee per month rate. The amount of the service fee varies due to the size of the group. The service fee is directed to an account segregated from the trust account and is not included with the monthly trust contributions. Only participating employers, not employees, are required to pay the monthly service fee. The service fee represents a uniform application of the costs and services related to the establishment, design and promotion of the Plan for the benefits of the participating employers, and include Sponsor Board services, and costs of other service related to the Sponsor Board's functions.

Plan Termination

Although the Plan has not expressed any intention to do so, HPMPT Sponsor Organization, Inc. (the Sponsor) has the right under the Plan to modify the benefits provided to active employees, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions set forth in ERISA. In the event of termination, the Plan shall distribute excess net assets in a uniform and nondiscriminatory manner for the provision of medical, dental and prescription, or other permitted welfare benefits to the persons who were participants at the time of termination. No assets of the Plan may revert to the Sponsor or be used for purposes other than for the exclusive benefit of the Plan's participants.

Note 2 - Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared on the accrual basis of accounting.

Use of Estimates

The preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts of assets and liabilities and changes therein, benefit obligations and changes therein, and disclosures of contingent assets and liabilities. Actual results may differ from those estimates.

Payment for Benefits

Claims payments are recorded when paid by the third-party claims processor. Amounts due to the claims processor that have yet to be reimbursed by the Plan are recorded as payable to claims administrators in the accompanying statements of net assets available for benefits. These payments are recorded as claims paid in the accompanying statement of changes in net assets available for benefits.

Stop Loss

Premiums for stop loss insurance are included in premium payments in the accompanying statement of changes in net assets available for benefits. Stop loss reimbursements and recoveries totaling \$979,704 for the year ended December 31, 2024, have been shown as a reduction of claims paid in the accompanying statement of changes in net assets available for benefits.

Refunds and Rebates

Refunds due from the Plan's pharmacy benefit manager are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against claims paid. Pharmacy rebates totaling \$993,298 have been netted with claims paid in the accompanying statement of changes in net assets available for benefits for the year ended December 31, 2024.

Cash and Cash Equivalents

The Plan considers all highly liquid investments with a maturity of three months or less when purchased to be cash and cash equivalents.

Receivables and Allowance for Credit Losses

The Plan has tracked historical loss information for its receivables and determined that all receivables are fully collectible and no allowance for credit losses is needed.

Management believes that the historical loss information it has compiled is a reasonable base on which to determine expected credit losses for receivables held at December 31, 2024 and 2023, because the composition of the receivables at those dates is consistent with that used in developing the historical credit expectations (i.e. the similar risk characteristics of its receivables). Additionally, management has determined that the current and reasonable and supportable forecasted economic conditions are consistent with the economic conditions included in the historical information. As a result, the historical loss rates have not been adjusted for differences in current conditions or forecasted changes. Accordingly, the allowance for credit losses at December 31, 2024 and 2023, is \$-0-.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for discussion of fair value measurements.

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

The classification of investment earnings reported in the statement of changes in net assets available for benefits may differ from the classification of earnings on Form 5500 due to different reporting requirements on Form 5500.

Expenses

Administrative expenses incurred in the administration of the Plan that are paid by the Plan include claims administration, accounting and auditing fees, legal fees, actuary and consulting fees, underwriting fees, and other administration fees. These expenses are recorded as deductions in the accompanying statement of changes in net assets available for benefits.

Benefit Obligations

Plan obligations at December 31, 2024 and 2023, for health claims incurred by participants but not reported at that date are estimated by an actuarial consulting firm based on industry accepted actuarial methods and assumptions. Such estimated amounts are included in the accompanying statements of the benefit obligations in the amounts currently payable.

Subsequent Events

The Plan Sponsor has evaluated subsequent events through September 25, 2025, the date which the financial statements were available to be issued.

Note 3 - Fair Value Measurements

The framework for measuring fair value provides a fair value hierarchy that prioritized the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under the FASB ASC 820 are described as follows:

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

Level 2 – Inputs to the valuation methodology include:

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

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

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

Health Professions of Montana Plan and Trust

Notes to Financial Statements
December 31, 2024 and 2023

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

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

Mutual funds (including money market mutual funds) – Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-ended mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

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

	2024			
	Level 1	Level 2	Level 3	Total
Mutual funds - fixed income	\$ 1,746,199	\$ -	\$ -	\$ 1,746,199
Mutual funds - equities	744,093	-	-	744,093
Money market mutual funds	1,745,769	-	-	1,745,769
Investments at fair value	\$ 4,236,061	\$ -	\$ -	\$ 4,236,061
	2023			
	Level 1	Level 2	Level 3	Total
Mutual funds - fixed income	\$ 1,628,245	\$ -	\$ -	\$ 1,628,245
Mutual funds - equities	709,676	-	-	709,676
Money market mutual funds	1,665,037	-	-	1,665,037
Investments at fair value	\$ 4,002,958	\$ -	\$ -	\$ 4,002,958

Note 4 - Tax Status

The Trust established under the Plan to hold the Plan's assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code and, accordingly, the Trust's income is exempt from income taxes. The Trust is considered tax-exempt under Section 501(c)(9) of the Internal Revenue Code and has received a favorable tax determination letter from the Internal Revenue Service dated June 3, 2011. The Plan Sponsor believes that the Trust, as amended, qualifies and operates in accordance with applicable provision of the Internal Revenue Code.

Although tax-exempt health and welfare benefit plans are not generally subject to taxation, certain activities of the Plan may be taxable. The investment income of a VEBA may be subject to unrelated business income tax (UBIT) to the extent that assets exceed certain account limits. The Plan has accrued an income tax receivable (payable) of \$156 and (\$63,244) related to UBIT as of December 31, 2024 and 2023, respectively, and income tax expense of \$101,000 for the year ended December 31, 2024.

As a matter of law, the Trust is subject to examination by federal and state taxing authorities. Although management believes that the amounts reflected in the information returns substantially comply with the applicable federal tax regulations, both the IRS and DOL and the various state taxing authorities can take positions contrary to management's position based on their interpretation of the law. The Trust has determined they are subject to examination of their federal information return filings in the United States for the preceding three tax years. A tax position that is challenged by a taxing authority could result in penalties and interest being assessed to the Trust. If this occurred, the Trust would record these as administrative expenses.

Note 5 - Income Taxes

The Plan is subject to federal and state income taxes related to UBTI. The provision for income taxes was as follows for the year ended December 31, 2024:

	<u>2024</u>
Current taxes	\$ 79,000
Deferred taxes	<u>22,000</u>
Total provision (benefit) for income taxes	<u><u>\$ 101,000</u></u>

Deferred income taxes are provided for the temporary differences between the financial reporting basis and the tax basis of the Plan's investments. Differences are attributable to unrealized appreciation (depreciation) on investments.

For the years ended December 31, 2024 and 2023, the effective tax rate approximated the federal and state statutory rate on capital gains of 26.75%.

Health Professions of Montana Plan and Trust

Notes to Financial Statements
December 31, 2024 and 2023

The deferred income taxes recognized in the statements of net assets available for benefits at December 31, 2024 and 2023, were as follows:

	2024	2023
Deferred tax asset (liability)		
Capital Loss Carryforward	\$ 25,960	\$ 10,093
Unrealized (appreciation) / depreciation on investments	(10,278)	27,589
	\$ 15,682	\$ 37,682

Cash payments for income taxes, net of refunds received, amounted to \$142,400 and \$3,112 for the years ended December 31, 2024 and 2023, respectively.

As of December 31, 2024, the Plan had \$97,046 of federal and state capital loss carry forwards, which do not expire.

Note 6 - Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Market risks include global events which could impact the value of investment securities, such as a pandemic or global conflict. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to claim utilization rates and healthcare costs, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term, would be material to the financial statements.

The estimated pharmacy rebate receivable is recorded monthly at the contracted rate. The estimated amount is reconciled to the contract terms when the information becomes available. Due to uncertainties inherent in the estimation, it is at least reasonably possible that changes in this estimate could materially affect the amount reported in the statements of net assets available for benefits.

The estimated stop loss recovery receivable is based on claims incurred over the stop loss limits in which reported claims are subject to change. Due to uncertainties inherent in the estimates and assumptions process, it is at least reasonably possible that changes in this estimate could materially affect the amount reported in the statements of net assets available for benefits.

Note 7 - Concentration of Credit Risk

The Plan maintains its cash in bank deposit accounts which exceed federally insured limits. Accounts are guaranteed by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 per depositor, per insured bank, for each account ownership category. At December 31, 2024 and 2023, the Plan had approximately \$123,000 and \$420,200, respectively, in excess of FDIC-insured limits.

Note 8 - Required Statutory Reserves

Under statutory regulations for multiple employer welfare associations operating in the State of Montana, the Plan is required to maintain reserves of at least 30% of the total of the claims incurred but not reported. At December 31, 2024 and 2023, the minimum required reserves were \$573,000 and \$356,667, respectively. The Plan held excess reserves of \$3,038,267 and \$3,638,176 at December 31, 2024 and 2023, respectively.

Note 9 - Related Party and Party-in-Interest Transactions

The Plan has a contract with HPMPT Sponsor Organization, Inc., the Plan Sponsor, for administrative services. The Plan paid HPMPT Sponsor Organization, Inc. approximately \$392,000 for administrative, outreach, and marketing services during the year ended December 31, 2024.

The Plan also paid approximately \$996,000 during the year ended December 31, 2024, to other parties-in-interest for administrative services that included third party claims administration, accounting, auditing, actuarial, legal, and other administrative fees. These transactions are considered exempt party-in-interest transactions under ERISA.

Note 10 - Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at December 31, 2024 and 2023, to Form 5500:

	2024	2023
Net assets available for benefits per the financial statements	\$ 5,678,267	\$ 5,335,734
Benefit obligations currently payable (claims payable and claims incurred but not reported)	(1,910,000)	(1,188,891)
Estimated unpaid claims administration expenses	(157,000)	(152,000)
Net assets available for benefits per Form 5500	\$ 3,611,267	\$ 3,994,843

Health Professions of Montana Plan and Trust

Notes to Financial Statements

December 31, 2024 and 2023

The following is a reconciliation of payments for benefits per the financial statements to the Form 5500 for the year ended December 31, 2024:

Benefits paid to participants per the financial statements	\$ 12,878,149
Add benefit obligations currently payable at end of current year	2,067,000
Less benefit obligations currently payable at end of prior year	<u>(1,340,891)</u>
Benefits paid to participants per Form 5500	<u>\$ 13,604,258</u>

Claims and premiums that have been processed and approved for payment at year end but not paid and claims incurred but not reported are not considered liabilities under GAAP and, therefore, are not presented as liabilities or claims and premiums paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

Supplementary Information

December 31, 2024

Health Professions of Montana Plan and Trust

Health Professions of Montana Plan and Trust

Schedule of Administrative Expenses

Year Ended December 31, 2024

Claims Administration	\$ 624,019
Administrative and Soliciting	325,350
Actuary and Consulting	149,240
Accounting and Auditing	116,908
Underwriting	87,953
Legal Fees	60,000
Insurance	10,077
Conferences and Meetings	2,683
	<hr/>
	\$ 1,376,230
	<hr/> <hr/>

Health Professions of Montana Plan and Trust
Schedule H, Line 4i – Schedule of Assets Held at End of Year
Year Ended December 31, 2024
Plan: 550

EIN: 45-2078503

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Cost	Current Value	
Mutual Funds - Fixed Income				
Nuveen Core Bond CI R6	43,934.521 shares	\$ 461,147	\$ 396,729	
Baird Aggregate Bond Intl	40,897.411 shares	451,022	394,660	
Ishares National Muni Bond ETF	3,575.000 shares	385,973	380,916	
Pgim Total Return Bond CI R6	23,102.608 shares	275,647	273,535	
Ishares Core U.S Aggregate Bond ETF	2,398.000 shares	234,563	232,366	
Ishares Trust Ishares 5 10 year ETF	1,320.000 shares	68,118	67,993	
Mutual Funds - Equities				
Fidelity 500 Index	1,713.544 shares	228,734	349,889	
Fidelity Mid Cap Index	5,161.256 shares	144,260	174,296	
Fidelity Emrg Markets Index	6,958.513 shares	72,770	72,786	
Fidelity Intl Index	1,588.395 shares	67,138	75,512	
Mondrian Intl Value Equity	2,470.019 shares	36,009	34,704	
Clearbridge Intl Growth	570.954 shares	31,338	36,906	
Money Market Mutual Funds				
First Am Govt Ob Fd CI Z	1,714,623.780 shares	1,714,624	1,714,624	
First Am Govt Ob Fd CI X	27,401.660 shares	27,402	27,402	
US Bank Money Market		3,743	3,743	
Total		<u>\$ 4,202,488</u>	<u>\$ 4,236,061</u>	

Health Professions of Montana Plan and Trust

Schedule H, Line 4j – Schedule of Reportable Transactions

December 31, 2024

Plan: 550

EIN: 45-2078503

(a) Identity of Party Involved	(b) Description of Asset	(c) Number of Transactions	(d) Purchase Price	(e) Selling Price	(f) Lease Rental	(g) Expense Incurred with Transaction	(h) Cost of Asset	(i) Current Value of Asset on Transaction Date	(j) Net Gain or (Loss)
US Bank	Fidelity US Bond Index	1	\$ -	\$ 309,754	n/a	n/a	\$ 322,129	\$ 309,754	\$ (12,375)
US Bank	Ishares National Muni Bond ETF	2	\$ 385,973	\$ -	n/a	n/a	\$ 385,973	\$ 385,973	n/a
US Bank	Pgim Total Return Bond CI R6	3	\$ 316,025	\$ -	n/a	n/a	\$ 316,025	\$ 316,025	n/a

Plan Name: Health Professions of Montana Plan & Trust (HPMPT)
EIN: 45-2078503
Plan Number: 550
Attachment: Schedule of Assets Held at End of Year

See Attached Accountant's Opinion

EXTENSION GRANTED UNTIL OCTOBER 15, 2025

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210 - 0110
1210 - 0089

2024

This Form is Open to Public Inspection

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 [x] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is: [] a single-employer plan [] a DFE (specify)
[] 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: [x] 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

1a Name of plan: HEALTH PROFESSIONS OF MONTANA PLAN & TRUST
1b Three-digit plan number (PN): 550
1c Effective date of plan: 05/01/2008
2a Plan sponsor's name (employer, if for a single-employer plan): HEALTH PROFESSIONS OF MONTANA PLAN & TRUST
Mailing address (include room, apt., suite no. and street, or P.O. Box): PO BOX 9406
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions): MISSOULA MT 59807
2b Employer Identification Number (EIN): 45-2078503
2c Plan Sponsor's telephone number: 406-443-4919
2d Business code (see instructions): 525100

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.

DocuSigned by:

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Row 1: J. Bruce Robertson, M.D., 10/10/2025, J. Bruce Robertson, M.D.
Row 2: Signature of plan administrator, Date, Enter name of individual signing as plan administrator
Row 3: Signature of employer/plan sponsor, Date, Enter name of individual signing as employer or plan sponsor
Row 4: Signature of DFE, Date, Enter name of individual signing as DFE

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor HPMPT BOARD OF TRUSTEES PO BOX 9406 MISSOULA MT 59807	3b Administrator's EIN 71-1029753 3c Administrator's telephone number 406-443-4919
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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	1,310
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	6a(1)	1,301
a (2) Total number of active participants at the end of the plan year	6a(2)	1,297
b Retired or separated participants receiving benefits	6b	8
c Other retired or separated participants entitled to future benefits	6c	2
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	1,307
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g (1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
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:

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

4A

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

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u> 2 </u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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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 000164953278

Name	EIN	%
Medical Eye Specialists	81-0309952	2.35%
Psychiatry Associates , PC	20-2456812	0.46%
Shiloh Medical Clinic	26-2271583	0.19%
Flathead Urology PLLC	56-2641614	0.30%
Montana Skin Cancer & Dermatology	46-3252946	1.39%
Alpine Women's Center PC	81-0529600	0.94%
MedNorth Urgent Care LLC	26-1459239	0.26%
Billings OBGYN Associates PC	81-0508020	2.79%
Gary Harvey MD PC	81-0494044	0.36%
Northwest Imaging	81-0347382	2.85%
Bridger Orthopedic	81-0512911	2.15%
Glacier Ear Nose & Throat	81-0364644	1.97%
Performance Injury Care & Sports Medicine	26-1100319	0.14%
Helena Lab Physicians	81-0339527	0.51%
Five Valleys Urology PLLC	65-1167362	1.80%
HPMPT Sponsor Organization	45-2078503	0.28%
Bighorn Valley Health Center	27-3113428	26.16%
Clark Fork Emergency Physicians PLLC	20-8603729	0.77%
Partners in Pediatrics	33-1070964	1.63%
Providence Surgery Center	84-1401625	1.55%
The Childrens Clinic of Billings PC	81-0349230	2.19%
Helena Pediatric Clinic	81-0505600	1.02%
Lewis & Clark Emergency Physicians	84-1424652	0.66%
Billings Anesthesiology PC	81-0483340	1.53%
Ophthalmic Associates of Billings LLC	35-2187746	0.31%
Anesthesia Partners of Montana	81-0478374	2.89%
Great Falls Surgical Associates	01-0721166	0.56%
Village Doc PLLC	47-4782911	0.17%
Gallatin Valley Anesthesia PC	13-4310888	2.86%
Partners in Home Care	81-0425934	8.79%
Missoula Pediatric Associates PC	47-3779198	0.43%
Yellowstone Pathology Institute Inc	81-0518775	1.73%
Gallatin Plastic Surgery	81-1441356	0.22%
Christopher Paris MD	37-1448877	0.06%
Montana Hospital Association	81-0287203	1.86%
Alpine Oral & Facial Surgery	81-0522488	0.66%
Scott C Wyman MD PC	47-4300376	0.49%
Kalispell Obstetrics & Gynecology PLLC	42-1611985	0.84%
Heuser Physical Therapy	20-0448578	0.92%
Bullhook Community Health Center	20-5970239	2.42%
Intercity Radiology PC	81-0306157	2.93%
Pure Health DPC LLC	82-5059734	0.13%
Billings Plastic Surgery	81-0374762	1.19%

Name	EIN	%
Ridgway Plastic Surgery	82-1786660	0.40%
Ascension Physical Therapy	47-4751637	0.64%
Cardiovascular Consultants of Montana	26-3576221	0.23%
Dr. Kevin McPherson DDS	46-2404123	0.19%
Ash Dental Management	47-3474305	0.13%
Stokke Family Dentistry	81-4865950	0.23%
Aimee Ameline DDS PC	20-5645722	0.18%
Glacier Eye	81-0401208	4.33%
Healthcare Providers Pharmacy	27-1142620	0.47%
Mint Dental LLC	83-1942034	0.66%
Bartoletti Dental	82-4142758	0.38%
Newton B Coutinho MD PLLC	73-1704214	0.12%
Rocky Mountain Dental	47-5546248	0.21%
Pediatric Dentistry PC	20-1362368	0.35%
Bridge Creek Dental	20-2924791	0.54%
Kevin A Miltko	81-0503321	0.12%
JKW & JIRA Inc	81-0537028	0.29%
Sidney Eye Care	45-5320225	0.05%
Booth Dental PC	82-3782135	0.20%
Rehability PC	20-2982107	0.20%
Montana Retina Consultants	85-2299228	0.20%
Eyes on Main	45-3008710	0.30%
Creger Family Eye Care PC	81-0526304	0.34%
Stephen J Spencer DDS PLLC	81-0412970	0.10%
Helena Orthodontics	27-1449864	0.12%
Benton Pharmacy	81-0438647	0.21%
Axis Physical Therapy	20-2520389	0.36%
Sapphire Dental	20-3395847	0.17%
Alpenglow Dental	26-3653423	0.08%
Public Drug Co.	81-0220115	0.32%
Mountain West Plastic Surgery and Medical Spa	88-2817728	0.22%
Healthy Smiles Dental Group	81-0520988	0.25%
Pharm406, Inc.	82-5421579	0.15%
Rimrock Podiatry	84-1367703	0.42%
Montana Eyecare	81-0529327	0.92%
Helena Vision Center	81-0395904	0.34%
Deep Roots Counseling	92-2230699	0.12%
Gallatin Valley Vision	81-2001860	0.08%
Neighborhood Dental	46-1063244	0.11%
Hays Dental Group	82-3489478	0.82%
Heffernan Drug, Inc. dba Lolo Drug	82-3107209	0.37%
Molar System	85-4011863	0.21%
Samara Therapy Specialists	85-1862321	0.04%

Name	EIN	%
Healthy Beginnings Pediatric Therapy	81-5384994	<u>0.10%</u>
		100%

Plan Name: Health Professions of Montana Plan & Trust (HPMPT)
EIN: 45-2078503
Plan Number: 550
Attachment: Schedule of Five Percent Transactions

See Attached Accountant's Opinion