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|---|---|---|
| <p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold; text-align: center;">2024</p> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection</p> |
|---|---|---|

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

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description) KENTUCKY STORM RELIEF 3624-EM

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

Part II Basic Plan Information—enter all requested information

| | |
|--|--|
| <p>1a Name of plan <u>APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>005</u></p> |
| <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>APPALACHIAN REGIONAL HEALTHCARE INC</u></p> <p><u>100 AIRPORT GARDENS ROAD</u> <u>HAZARD, KY 41701</u></p> | <p>1c Effective date of plan <u>01/01/1986</u></p> <p>2b Employer Identification Number (EIN) <u>52-0795508</u></p> <p>2c Plan Sponsor's telephone number <u>859-226-2469</u></p> <p>2d Business code (see instructions) <u>622000</u></p> |

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

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

| | | | |
|------------------|---|------------|--|
| SIGN HERE | Filed with authorized/valid electronic signature. | 11/03/2025 | SONYA BERGMAN |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

| | | |
|---|--|-----|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 465 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6a(1) | 436 |
| | 6a(2) | 555 |
| | 6b | 4 |
| | 6c | 30 |
| | 6d | 589 |
| | 6e | 3 |
| | 6f | 592 |
| | 6g(1) | 465 |
| 6g(2) | 592 | |
| 6h | 0 | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | |

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2F 2G 2L 2M 2R 2T

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

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

| | | |
|---|--|-------------------|
| <p>A Name of plan APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>005</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 APPALACHIAN REGIONAL HEALTHCARE INC</p> | <p>D Employer Identification Number (EIN) 52-0795508</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
MUTUAL OF AMERICA LIFE INSURANCE CO.

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 13-1614399 | 88668 | 006754-D | 245 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|----------|---------|
| 4 Current value of plan's interest under this contract in the general account at year end | 4 | 7192539 |
| 5 Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 9126026 |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

| | | |
|--|-----------|--|
| b Premiums paid to carrier | 6b | |
| c Premiums due but unpaid at the end of the year | 6c | |
| d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | 6d | |

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

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

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

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

| | | |
|--|-----------|---------|
| b Balance at the end of the previous year | 7b | 7772120 |
|--|-----------|---------|

| | | | |
|---|--------------|--------|--|
| c Additions: (1) Contributions deposited during the year | 7c(1) | | |
| | 7c(2) | | |
| | 7c(3) | 214756 | |
| | 7c(4) | | |
| | 7c(5) | 122793 | |
| ▶ TRANSFERS | | | |

| | | |
|---------------------------|--------------|--------|
| (6) Total additions | 7c(6) | 337549 |
|---------------------------|--------------|--------|

| | | |
|---|-----------|---------|
| d Total of balance and additions (add lines 7b and 7c(6)) | 7d | 8109669 |
|---|-----------|---------|

| | | | |
|--|--------------|--------|--|
| 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) | 915626 | |
| | 7e(2) | 1504 | |
| | 7e(3) | | |
| | 7e(4) | | |
| ▶ | | | |

| | | |
|----------------------------|--------------|--------|
| (5) Total deductions | 7e(5) | 917130 |
|----------------------------|--------------|--------|

| | | |
|--|-----------|---------|
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 7192539 |
|--|-----------|---------|

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 |
| 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. ▶

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|----------------------------|--|---------------------|
| | Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 2548950 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 6654377 |
| 6 | Contracts With Allocated Funds: | |
| a | State the basis of premium rates ▶ | |
| b | Premiums paid to carrier | 6b |
| c | Premiums due but unpaid at the end of the year | 6c |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | 6d |
| e | Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | |
| f | If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | |
| 7 | Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | |
| a | Type of contract: (1) <input checked="" type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | |
| b | Balance at the end of the previous year | 7b 2636235 |
| c | (1) Contributions deposited during the year | 7c(1) |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 99546 |
| | (4) Transferred from separate account | 7c(4) 9284 |
| | (5) Other (specify below)..... ▶ LOAN PAYMENTS | 7c(5) 1561 |
| | (6) Total additions | 7c(6) 110391 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 2746626 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 197647 |
| | (2) Administration charge made by carrier..... | 7e(2) 29 |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ | 7e(4) |
| (5) Total deductions | 7e(5) 197676 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 2548950 |

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

| | | |
|---|--|-------------------|
| <p>A Name of plan APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>005</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 APPALACHIAN REGIONAL HEALTHCARE INC</p> | <p>D Employer Identification Number (EIN) 52-0795508</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
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 36-6071399 | 70688 | TT069357 | 172 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|----------|----|
| 4 Current value of plan's interest under this contract in the general account at year end | 4 | 29 |
| 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 | 0 | |
| c Additions: (1) Contributions deposited during the year | 7c(1) | | |
| | 7c(2) | | |
| | 7c(3) | 1 | |
| | 7c(4) | | |
| | 7c(5) | 4214 | |
| | ▶ EBA ADDITIONS | | |
| (6) Total additions | 7c(6) | 4215 | |
| d Total of balance and additions (add lines 7b and 7c(6)) | 7d | 4215 | |
| e Deductions: | | | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | (2) Administration charge made by carrier | 7e(2) | 4186 |
| | (3) Transferred to separate account | 7e(3) | |
| | (4) Other (specify below) | 7e(4) | |
| ▶ | | | |
| (5) Total deductions | 7e(5) | 4186 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 29 | |

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

| | | |
|---|--|--|
| <p>A Name of plan APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</p> | <p>B Three-digit plan number (PN) ▶ 005</p> | |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 APPALACHIAN REGIONAL HEALTHCARE INC</p> | <p>D Employer Identification Number (EIN) 52-0795508</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
TRANSAMERICA LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 39-0989781 | 86231 | TT069357 | 172 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Part II | Investment and Annuity Contract Information | |
|---|---|--------------------|
| Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. | | |
| 4 | Current value of plan's interest under this contract in the general account at year end | 4 262687 |
| 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. Specify nature of costs ▶ | 6d |
| e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | | |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | | |
| 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | | |
| a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | | |
| b | Balance at the end of the previous year | 7b 257832 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) 5583 |
| | (2) Dividends and credits..... | 7c(2) |
| | (3) Interest credited during the year..... | 7c(3) 6678 |
| | (4) Transferred from separate account | 7c(4) |
| | (5) Other (specify below)..... ▶ TRANSFER IN AND LOAN PAYMENTS | 7c(5) 30316 |
| | (6) Total additions | 7c(6) 42577 |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 300409 |
| e Deductions: | | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 7063 |
| | (2) Administration charge made by carrier..... | 7e(2) 1300 |
| | (3) Transferred to separate account | 7e(3) |
| | (4) Other (specify below)..... ▶ TRANSFER OUT AND LOANS ISSUED | 7e(4) 29359 |
| | (5) Total deductions | 7e(5) 37722 |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 262687 |

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

| | | |
|---|--|------------|
| A Name of plan APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN | B Three-digit plan number (PN) ▶ | 005 |
| C Plan sponsor's name as shown on line 2a of Form 5500 APPALACHIAN REGIONAL HEALTHCARE INC | D Employer Identification Number (EIN) 52-0795508 | |

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

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

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

CHARLES SCHWAB & CO., INC

94-1737782

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

VOYA RETIREMENT INSURANCE AND ANNUI

71-0294708

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

MUTUAL OF AMERICA FINANCIAL GROUP

52-0795508

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

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

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

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

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

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

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

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

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

| (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? |
|---|---|--|--|--|---|--|
| 12 15 28 37 38 50 54 59 61 62 63 64 65 | RECORD KEEPER | 12865 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

NATIONAL FINANCIAL SERVICES

04-3523567

| (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? |
|------------------------|---|--|--|--|---|--|
| 33 71 | SECURITIES BROKER | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

MUTUAL OF AMERICA LIFE INSURANCE CO

320 PARK AVENUE
NEW YORK, NY 10022

| (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? |
|------------------------|---|--|--|--|---|--|
| 12 15 37 65 | RECORD KEEPER | 1888 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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)

CHARLES SCHWAB & CO., INC.

94-1737782

| (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? |
|------------------------|---|--|--|--|---|--|
| 33 71 | SECURITIES BROKER | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

VOYA RETIREMENT INS AND ANNUITY CO

71-0294708

| (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? |
|------------------------|---|--|--|--|---|--|
| 12 15 37 65 | RECORDKEEPIN G | 100 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

| (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 |
|---|--|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| ARISTOTLE PO BOX 701 MILWAUKEE, WI 53201 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| BLACKROCK 40 EAST 52ND ST NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| COHEN & STEERS 280 PARK AVENUE NEW YORK, NY 10017 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |

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 |
|--|--|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| HOOD RIVER 2373 PGA BLVD SUITE 200 PALM BEACH GARDENS, FL 33410 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| VIRTUS 101 MUNSON STREET GREENFIELD, MA 01301 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| ARISTOTLE PO BOX 701 MILWAUKEE, WI 53201 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |

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 |
|--|--|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| BLACKROCK 40 EAST 52ND ST NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| COHEN & STEERS 280 PARK AVENUE NEW YORK, NY 10017 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| HOOD RIVER 2373 PGA BLVD SUITE 200 PALM BEACH GARDENS, FL 33410 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |

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 |
|--|--|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| VIRTUS 101 MUNSON STREET GREENFIELD, MA 01301 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| CHARLES SCHWAB & CO., INC | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| ALLIANZ GLOBAL INVESTORS 1633 BROADWAY NEW YORK, NY 10019 | RATE OF 0.40% OF AVERAGE DAILY BALANCE OF ASSET(S) | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| CHARLES SCHWAB & CO., INC | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| RBC GLOBAL ASSET MANAGEMENT. 50 SOUTH 6TH STREET SUITE 2350 MINNEAPOLIS, MN 55402 | RATE OF 0.20% OF AVERAGE DAILY BALANCE OF ASSET(S) | |

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 |
|---|--|---|
| CHARLES SCHWAB & CO., INC | 33 71 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| SCHWAB FUNDS 94-3106735 | RATE OF 0.25% OF AVERAGE DAILY BALANCE OF ASSET(S) | |
| (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 D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> | DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection. |
|---|--|---|

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

| | | |
|--|---|------------|
| A Name of plan <u>APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</u> | B Three-digit plan number (PN) ▶ | <u>005</u> |
|--|---|------------|

| | |
|--|--|
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>APPALACHIAN REGIONAL HEALTHCARE INC</u> | D Employer Identification Number (EIN) <u>52-0795508</u> |
|--|--|

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

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT NO. 2

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA LIFE INS. CO.

| | | |
|---------------------------------------|-------------------------------|--|
| c EIN-PN <u>13-1614399-000</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>9126026</u> |
|---------------------------------------|-------------------------------|--|

a Name of MTIA, CCT, PSA, or 103-12 IE: MAPV ACCOUNT C D

b Name of sponsor of entity listed in (a): VOYA RETIREMENT INSURANCE & ANNUITY CO

| | | |
|---------------------------------------|-------------------------------|--|
| c EIN-PN <u>71-0294708-000</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>6654377</u> |
|---------------------------------------|-------------------------------|--|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

| | |
|---|--|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 | |
| A Name of plan APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN | B Three-digit plan number (PN) ▶ 005 |
| C Plan sponsor's name as shown on line 2a of Form 5500 APPALACHIAN REGIONAL HEALTHCARE INC | D Employer Identification Number (EIN) 52-0795508 |

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

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

| | (a) Beginning of Year | (b) End of Year |
|--|-----------------------|------------------------|
| Assets | | |
| a Total noninterest-bearing cash | 1a | |
| b Receivables (less allowance for doubtful accounts): | | |
| (1) Employer contributions | 1b(1) | |
| (2) Participant contributions | 1b(2) | 5655 0 |
| (3) Other | 1b(3) | 40 139 |
| c General investments: | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | |
| (2) U.S. Government securities | 1c(2) | |
| (3) Corporate debt instruments (other than employer securities): | | |
| (A) Preferred | 1c(3)(A) | |
| (B) All other | 1c(3)(B) | |
| (4) Corporate stocks (other than employer securities): | | |
| (A) Preferred | 1c(4)(A) | |
| (B) Common | 1c(4)(B) | |
| (5) Partnership/joint venture interests | 1c(5) | |
| (6) Real estate (other than employer real property) | 1c(6) | |
| (7) Loans (other than to participants) | 1c(7) | |
| (8) Participant loans | 1c(8) | 39333 28719 |
| (9) Value of interest in common/collective trusts | 1c(9) | |
| (10) Value of interest in pooled separate accounts | 1c(10) | 15111135 15780403 |
| (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) | 3029454 3364648 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | 10666187 10004205 |
| (15) Other | 1c(15) | 44213 46324 |

| 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 | 28896017 | 29224438 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | | |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | | |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | | |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 28896017 | 29224438 |

Part II Income and Expense Statement

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

| Income | | (a) Amount | (b) Total |
|--|-----------------|------------|-----------|
| a Contributions: | | | |
| (1) Received or receivable in cash from: (A) Employers..... | 2a(1)(A) | | |
| (B) Participants..... | 2a(1)(B) | 153720 | |
| (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) | | 153720 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | | |
| (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) | 1960 | |
| (F) Other..... | 2b(1)(F) | 320981 | |
| (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | | 322941 |
| (2) Dividends: | | | |
| (A) Preferred stock..... | 2b(2)(A) | | |
| (B) Common stock..... | 2b(2)(B) | | |
| (C) Registered investment company shares (e.g. mutual funds)..... | 2b(2)(C) | 74477 | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 74477 |
| (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) | | 2842684 |
| (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) | | 347578 |
| c Other income | 2c | | 2111 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 3743511 |

Expenses

| | | | |
|---|---------------|---------|---------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 3396051 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | | |
| (3) Other | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 3396051 |
| f Corrective distributions (see instructions) | 2f | | |
| g Certain deemed distributions of participant loans (see instructions) | 2g | | |
| h Interest expense | 2h | | |
| i Administrative expenses: | | | |
| (1) Salaries and allowances | 2i(1) | | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Recordkeeping fees | 2i(3) | 14853 | |
| (4) IQPA audit fees | 2i(4) | | |
| (5) Investment advisory and investment management fees | 2i(5) | 4186 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | | |
| (7) Actuarial fees | 2i(7) | | |
| (8) Legal fees | 2i(8) | | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses | 2i(11) | | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 19039 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 3415090 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|--------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 328421 |
| 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: **CHERRY BEKAERT LLP**

(2) EIN: **56-0574444**

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 | | 10000000 |
| 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 _____.

| | | |
|--|---|---|
| SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection. |
|--|---|---|

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

| | | |
|---|--|------------|
| A Name of plan <u>APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN</u> | B Three-digit plan number (PN) ▶ | <u>005</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>APPALACHIAN REGIONAL HEALTHCARE INC</u> | D Employer Identification Number (EIN) <u>52-0795508</u> | |

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

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

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

| | | |
|---|--|---|
| 1 | | 0 |
|---|--|---|

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
EIN(s): 13-1614399 71-0294708

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

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

| | | |
|---|--|---|
| 3 | | 8 |
|---|--|---|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part VII IRS Compliance Questions

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

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

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

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

FINANCIAL STATEMENTS AND SUPPLEMENTAL SCHEDULES

*As of December 31, 2024 and 2023, and June 30, 2023
and for the Year Ended December 31, 2024 and for the
Period from July 1, 2023 Through December 31, 2023*

And Report of Independent Auditor

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
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NOTE: All other schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

Report of Independent Auditor

To the Plan Administrator and Participants
Appalachian Regional Healthcare, Inc. Voluntary Plan
Lexington, Kentucky

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

We have performed audits of the financial statements of the Appalachian Regional Healthcare, Inc. Voluntary Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as permitted by ERISA Section 103(a)(3)(C). The financial statements comprise the statements of net assets available for benefits as of December 31, 2024 and 2023, and June 30, 2023 and the related statement of changes in net assets available for benefits for the year ended December 31, 2024 and for the period from July 1, 2023 through December 31, 2023, and the related notes to the financial statements.

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

Management has obtained certifications from qualified institutions as of December 31, 2024 and 2023, and June 30, 2023, and for the year ended December 31, 2024 and for the period from July 1, 2023 through December 31, 2023, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Opinion

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

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in *the 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 ERISA Section 103(a)(3)(C) audit opinion.

Responsibilities of Management for the Audit of 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 the financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

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

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

Other Matter – Supplemental Schedules Required by ERISA

The supplemental schedules, Schedules of Assets (Held at End of Year) – Form 5500, Schedule H, Part IV, Line 4i as of December 31, 2024 and 2023, are presented for purposes of additional analysis and are not a required part of the financial statements but is supplementary information required by DOL's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and to 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 to other additional procedures in accordance with generally accepted auditing standards. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

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

In our opinion:

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

Cherry Bekaert LLP

Louisville, Kentucky
November 3, 2025

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

| | <u>December 31, 2024</u> | <u>December 31, 2023</u> | <u>June 30, 2023</u> |
|--|--------------------------|--------------------------|----------------------|
| ASSETS | | | |
| Investments, at fair value | \$ 26,383,914 | \$ 25,956,922 | \$ 26,823,319 |
| Investments, at contract value | 2,811,666 | 2,894,067 | 2,946,956 |
| Receivables: | | | |
| Notes receivable from participants | 28,719 | 39,333 | 36,909 |
| Other | 139 | 40 | 357 |
| Participants | - | 5,655 | - |
| Total Receivables | <u>28,858</u> | <u>45,028</u> | <u>37,266</u> |
| Net Assets Available for Benefits | <u>\$ 29,224,438</u> | <u>\$ 28,896,017</u> | <u>\$ 29,807,541</u> |

The accompanying notes to the financial statements are an integral part of these statements.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEAR ENDED DECEMBER 31, 2024 AND
PERIOD FROM JULY 1, 2023 THROUGH DECEMBER 31, 2023

| | Year Ended December 31, 2024 | Period July 1, 2023 through December 31, 2023 |
|---|---|--|
| Additions to net assets attributed to: | | |
| Investment income: | | |
| Interest and dividends | \$ 395,458 | \$ 233,760 |
| Net appreciation in fair value of investments | 3,192,373 | 1,038,706 |
| Total Investment Income | 3,587,831 | 1,272,466 |
| Interest income on notes receivable from participants | 1,960 | 917 |
| Contributions: | | |
| Participant | 153,720 | 73,515 |
| Total Additions | 3,743,511 | 1,346,898 |
| Deductions from net assets attributed to: | | |
| Benefits paid to participants | 3,396,051 | 2,249,976 |
| Administrative fees | 19,039 | 8,446 |
| Total Deductions | 3,415,090 | 2,258,422 |
| Net increase (decrease) in net assets available for benefits | 328,421 | (911,524) |
| Net assets available for benefits, beginning of year and period | 28,896,017 | 29,807,541 |
| Net assets available for benefits, end of year and period | <u>\$ 29,224,438</u> | <u>\$ 28,896,017</u> |

The accompanying notes to the financial statements are an integral part of these statements.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 1—Description of the Plan

The following description of the Appalachian Regional Healthcare, Inc. Voluntary Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General – The Plan is a defined contribution annuity contract plan under Internal Revenue Code ("IRC") Section 403(b)(1) covering all employees of Appalachian Regional Healthcare, Inc. (the "Plan Sponsor" or "Employer") that are not eligible to participate in another plan of the Plan Sponsor which is a governmental 457(b), 401(k) or another 403(b) plan. An employee is eligible to participate in the Plan upon his or her hire date. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Administration – The Plan Sponsor has designated certain employees, who serve without additional compensation, to administer the Plan. The Plan administrator has the overall responsibility and authority as the named fiduciary to manage and control the operations and administration of the Plan and may designate one or more individuals to perform those responsibilities. The Plan provides for investments in insurance investment contracts, mutual funds, and separate accounts maintained by Voya Retirement Insurance and Annuity Company ("VOYA"), Mutual of America Life Insurance Company ("Mutual of America"), Transamerica Financial Life Insurance Company, Inc. ("TFLIC"), Transamerica Life Insurance Company ("TLIC"), and State Street Bank and Trust Company ("State Street"), the "custodians" for the Plan.

Change in Plan Year – Effective July 1, 2023, the Plan was amended to change the year end to December 31. The amendment allowed a short plan year beginning July 1, 2023 and ending December 31, 2023 and a new Plan year beginning January 1, 2024.

Contributions – Each year, participants may elect to contribute a percentage of their eligible annual pre-tax compensation, as defined by the Plan, not to exceed the annual maximum limit established by the IRC. Rollover contributions are allowed subject to approval by the Plan administrator. Catch-up contributions are also permitted by the Plan. Effective January 1, 2024, the Plan was amended to allow after-tax Roth contributions.

Participant Accounts – Individual accounts are maintained for each Plan participant. Each participant's account is credited with the participant's contributions and Plan earnings. Participant accounts are charged with an allocation of administrative expenses paid by the Plan. Allocations are based on participant earnings, specific participant transaction costs, or account balances, as defined. The benefit to which a participant is entitled is the benefit which can be provided from the participant's vested account.

Vesting – Participants are fully vested in their individual accounts.

Investment Options – Upon enrollment in the Plan, participants may direct the investment of their accounts into various investment options offered by the Plan. They may change their investment options among those investments provided at any time during the Plan year.

Notes Receivable from Participants – Participants may borrow from their individual accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 reduced by the balance of other loans outstanding or 50% of their vested account balance. Generally, the term of the loan may not exceed five years. However, if the loan is for the purchase of a participant's principal residence, the Plan administrator may permit a longer term. The loans are secured by the balance in the participant's account and bear interest at rates commensurate with local prevailing rates as determined by the Plan administrator. Principal and interest are repaid ratably through participants submitting payments directly to the custodians of the Plan.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 2—Summary of significant accounting policies

Payment of Benefits – Upon termination of service or attaining normal retirement age, a participant may elect to receive a lump sum amount equal to the value of the participant's vested interest in his or her account, or periodic annuity payments. In-service and hardship withdrawals are also allowed as defined in the Plan agreement.

Basis of Presentation – The financial statements of the Plan are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). The Accounting Standards Codification ("ASC") as produced by the Financial Accounting Standards Board ("FASB") is the sole source of authoritative U.S. GAAP.

Use of Estimates – The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and the disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

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

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

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

Payments of Benefits – Benefits are recorded when paid. There were no benefit payments requested and not yet disbursed at December 31, 2024 and 2023 and June 30, 2023.

Administrative Expenses – All administrative expenses of the Plan, with the exception of certain record keeping fees, are absorbed by the Plan Sponsor.

Investment Management Fees and Operating Expenses – Investment management fees and operating expenses charged to the Plan for investments in the various funds are deducted from income earned on a daily basis and are reflected as a component of net appreciation (depreciation) in fair values of investments.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 3—Information prepared and certified by qualified institutions (unaudited)

The Plan administrator has elected the method of annual reporting compliance permitted by ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, Voya, Mutual of America, TFLIC, TLIC, and State Street, qualified institutions, has certified to the completeness and accuracy of the following data including in the accompanying financial statements and supplemental schedules

- Investments at fair value and investments at contract value as shown in the statements of net assets available for benefits as of December 31, 2024 and 2023 and June 30, 2023.
- Net appreciation in fair value of investments and interest and dividends, as shown in the statement of changes in net assets available for benefits for the year ended December 31, 2024 and for the period from July 1 through December 31, 2023.
- Schedule of Assets (Held at End of Year) – Form 5500, Schedule H, Part IV, Line 4i as of December 31, 2024 and 2023.

At the request of the Plan administrator, the Plan's independent auditor did not perform auditing procedures with respect to this certified information, except for comparing such information to the related information included in the financial statements and supplemental schedule.

Note 4—Fair value measurements

U.S. GAAP provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy 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.

The asset 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.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 4—Fair value measurements (continued)

The following is a description of the valuation methodologies used for investments measured at fair value including the general classification of such assets pursuant to the valuation hierarchy. There have been no changes in the methodologies used at December 31, 2024, December 31, 2023, or June 30, 2023.

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.

Insurance General Account Investment Contracts – Valued based on terms specified in the contracts. The contracts are credited with declared rates of interest and are subject to a minimum rate described in the contract. At December 31, 2024 and 2023, and June 30, 2023, the fair value of these contracts approximated contract value. Contract value represents contributions made under each contract, plus earnings, less participant withdrawals and administrative expenses. The contracts are not fully benefit-responsive due to restrictions on the initiation of certain transactions in the contracts.

Sub-Accounts of Separate Account of an Insurance Company – Valued at the NAV of units held by the Plan at year-end provided by the issuer of the account. The NAV is used as a practical expedient to estimate fair value and is based on the value of the underlying investment assets held through sub-accounts of a separate account of an insurance company. This practical expedient is not used when it is determined to be probable that the account will sell the investment for an amount different than the reported NAV. Sub-accounts are comprised, primarily, of shares of mutual funds held through sub-accounts of an insurance company at December 31, 2024, and 2023, and June 30, 2023. The sub-accounts seek to mirror the investment objectives and strategies of the underlying mutual fund for which the sub-account is named. Certain sub-accounts are target date funds which seek capital appreciation and current income consistent with asset allocation that become more conservative over time to the specified retirement date. The investments are redeemable at the adjusted NAV on a daily basis under agreements with the insurance company. There are currently no redemption restrictions or unfunded commitments on these investments.

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

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 4—Fair value measurements (continued)

The following table sets forth by level, within the fair value hierarchy, the Plan's assets measured at fair value on a recurring basis at December 31, 2024 and 2023 and June 30, 2023:

| | December 31, 2024 | | | Total |
|--|-------------------|--------------|---------|---------------|
| | Level 1 | Level 2 | Level 3 | |
| Mutual funds | \$ 3,410,972 | \$ - | \$ - | \$ 3,410,972 |
| Insurance general account investment contracts | - | 7,192,539 | - | 7,192,539 |
| Total assets in the fair value hierarchy | \$ 3,410,972 | \$ 7,192,539 | \$ - | 10,603,511 |
| Investments measured at NAV (a) | | | | 15,780,403 |
| Investments, at fair value | | | | \$ 26,383,914 |

| | December 31, 2023 | | | Total |
|--|-------------------|--------------|---------|---------------|
| | Level 1 | Level 2 | Level 3 | |
| Mutual funds | \$ 3,073,667 | \$ - | \$ - | \$ 3,073,667 |
| Insurance general account investment contracts | - | 7,772,120 | - | 7,772,120 |
| Total assets in the fair value hierarchy | \$ 3,073,667 | \$ 7,772,120 | \$ - | 10,845,787 |
| Investments measured at NAV (a) | | | | 15,111,135 |
| Investments, at fair value | | | | \$ 25,956,922 |

| | June 30, 2023 | | | Total |
|--|---------------|--------------|---------|---------------|
| | Level 1 | Level 2 | Level 3 | |
| Mutual funds | \$ 2,996,460 | \$ - | \$ - | \$ 2,996,460 |
| Insurance general account investment contracts | - | 9,029,712 | - | 9,029,712 |
| Total assets in the fair value hierarchy | \$ 2,996,460 | \$ 9,029,712 | \$ - | 12,026,172 |
| Investments measured at NAV (a) | | | | 14,797,147 |
| Investments, at fair value | | | | \$ 26,823,319 |

(a) Certain investments measured at fair value using NAV as a practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

Note 5—Fully benefit-responsive investment contracts

The Plan has fully benefit-responsive investment contracts with Voya, TFLIC and TLIC (collectively, the "issuers"). The issuers maintain the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The guaranteed investment contracts are included in the financial statements at contract value as reported to the Plan by the issuers. Because the guaranteed investment contracts are fully benefit-responsive, contract value is the relevant measurement attributed for that portion of the net assets available for benefits of a defined contribution plan attributable to the guaranteed investment contracts. Contract value represents contributions made under the contracts, plus earnings, less participant withdrawals and administrative expense. Participants may ordinarily direct the withdrawal or transfer of all of a portion of their investment at contract value. The guaranteed investment contracts' issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed by the Plan. There are no reserves against contract value for credit risk of the contract issuer or otherwise.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN

NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 5—Fully benefit-responsive investment contracts (continued)

Certain events limit the ability of the Plan to transact at contract value with the issuers. Such events include the following: (1) amendments to the Plan documents (including complete or partial plan termination or merger with another plan), (2) changes to the Plan's prohibition on competing investment options or deletion of equity wash provisions, (3) bankruptcy of the Plan sponsor or other Plan sponsor events (for example, divestitures or spin-offs of a subsidiary) that cause a significant withdrawal from the Plan, or (4) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The Plan administrator does not believe that the occurrence of any such event which would limit the Plan's ability to transact at contract value with participants is probable.

The guaranteed investment contracts do not permit the issuers to terminate the agreement prior to the scheduled maturity date.

Note 6—Related party and party-in-interest transactions

Certain administrative services are provided by the Company at no cost to the Plan and certain administrative costs incurred by the Plan are paid by the Company. The Plan has entered into various service agreements with parties-in-interest. It invests in insurance contracts and sub-accounts managed by the custodians of the Plan. These transactions as well as notes receivable from participants and related activity qualify as party-in-interest.

Note 7—Income tax status

The Internal Revenue Service ruled on March 31, 2017, that the Volume Submitter 403(b) Plan of Frost Brown Todd LLC, upon which the Plan is based, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended since receiving the opinion letter. However, the Plan administrator believes the Plan is designed, and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, believes that the Plan is qualified and the related trust is tax-exempt.

U.S. GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2024, and 2023, and June 30, 2023, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Note 8—Plan termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA.

Note 9—Risks and uncertainties

The Plan invests in various investment securities. Investment securities, in general, are exposed to various risks, such as interest rate, market and credit risks. 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 such changes could materially affect participants' account balances and the amounts reported in the financial statements.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
NOTES TO THE FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023, AND JUNE 30, 2023

Note 10—Subsequent events

The Plan has evaluated all subsequent events through November 3, 2025, which is the date these financial statements were available to be issued and has determined there are no subsequent events that require disclosure.

SUPPLEMENTAL SCHEDULES

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2024

| (a) | (b) | (c) | (e) |
|---|--|-----------------------------------|-------------------|
| Identity of Issue, Borrower, Lessor or Similar Party | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value | December 31, 2024 |
| Mutual Funds: | | | |
| Cohen & Steers | Real Estate Securities Fund | \$ | 27,714 |
| Federated Hermes | MDT Mid Cap Gr R6 | | 48,868 |
| Fidelity | NASDAQ Composite Fund | | 147,389 |
| Hood River | Small Cap Growth Fund | | 63,563 |
| MFS | New Discovery Value Fund | | 23,702 |
| Pacific Funds | Floating Rate Income Advisor Fund | | 12,281 |
| Charles Schwab | Personal Choice Retirement Fund | | 46,324 |
| Principal | MidCap Value I R6 | | 40,153 |
| Charles Schwab | Fundamental US Large Company Index Fund | | 35,991 |
| Vanguard | 500 Index Fund | | 320,556 |
| Vanguard | Core Bond Admiral | | 36,207 |
| Vanguard | Global Credit Bond Adm | | 24,195 |
| Vanguard | International Growth Fund | | 126,004 |
| Vanguard | Mid Cap Index Fund | | 59,625 |
| Vanguard | Russell 1000 Growth Index Fund | | 244,766 |
| Vanguard | Small Cap Value Index | | 49,290 |
| Vanguard | Target Retirement 2020 Fund | | 104,037 |
| Vanguard | Target Retirement 2025 Fund | | 201,674 |
| Vanguard | Target Retirement 2030 Fund | | 128,520 |
| Vanguard | Target Retirement 2035 Fund | | 292,630 |
| Vanguard | Target Retirement 2040 Fund | | 164,375 |
| Vanguard | Target Retirement 2045 Fund | | 161,225 |
| Vanguard | Target Retirement 2050 Fund | | 509,895 |
| Vanguard | Target Retirement 2055 Fund | | 16,780 |
| Vanguard | Target Retirement Income Fund | | 277,603 |
| Vanguard | Treasury Money Market Fund | | 41,233 |
| Virtus | Newfleet Multi Sector Short Term Bond Fund | | 57,802 |
| iShares | MSCI EAFE International Index K | | 148,570 |
| | | | 3,410,972 |
| Fully Benefit-Responsive Investment Contracts: | | | |
| * | TLIC | Guaranteed Investment Fund Option | 262,687 |
| * | Voya | Fixed Account | 2,196,699 |
| * | Voya | Fixed Plus Account II | 141,111 |
| * | Voya | Fixed Plus Account | 115,025 |
| * | Voya | Long Term GAA | 82,255 |
| * | Voya | Short Term GAA | 13,889 |
| | | | 2,811,666 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2024

| (a) | (b) | (c) | (e) |
|--|--|--|-----------|
| Identity of Issue, Borrower, Lessor or Similar Party | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2024 | |
| Sub-Accounts of Separate Accounts of an Insurance Company (continued): | | | |
| * | Mutual of America | Aggressive Allocation | \$ 1,356 |
| * | Mutual of America | Moderate Allocation | 48,191 |
| * | Mutual of America | Bond Fund | 93,192 |
| * | Mutual of America | T. Rowe Price Blue Chip Growth Fund | 38,107 |
| * | Mutual of America | Composite Fund | 270,979 |
| * | Mutual of America | Calvert VP Social Balanced Portfolio | 145,732 |
| * | Mutual of America | Equity Index Fund | 1,682,731 |
| * | Mutual of America | Fidelity VIP Mid Cap Portfolio | 201,893 |
| * | Mutual of America | Fidelity VIP Asset Manager Portfolio | 25,477 |
| * | Mutual of America | Fidelity VIP Contrafund Portfolio | 1,528,966 |
| * | Mutual of America | Fidelity VIP Equity-Income Portfolio | 320,615 |
| * | Mutual of America | Goldman Sachs VIT Small Cap Equity Insights | 86,031 |
| * | Mutual of America | Money Market Fund | 582 |
| * | Mutual of America | Mid-Term Bond Fund | 25,729 |
| * | Mutual of America | Mid-Cap Equity Index Fund | 462,953 |
| * | Mutual of America | Mid Cap Value Fund | 47,488 |
| * | Mutual of America | International Fund | 67,928 |
| * | Mutual of America | Oppenheimer Main Street | 742 |
| * | Mutual of America | Retirement Income Fund | 141,247 |
| * | Mutual of America | Vanguard VIF REIT Index Portfolio | 10,173 |
| * | Mutual of America | PIMCO VIT Real Return Portfolio | 147,982 |
| * | Mutual of America | 2025 Retirement Fund | 255,799 |
| * | Mutual of America | 2030 Retirement Fund | 2,427 |
| * | Mutual of America | 2040 Retirement Fund | 280,736 |
| * | Mutual of America | 2045 Retirement Fund | 47,342 |
| * | Mutual of America | All America Fund | 227,737 |
| * | Mutual of America | DWS Capital Growth VIP Fund | 1,490,577 |
| * | Mutual of America | Small Cap Growth Fund | 239,325 |
| * | Mutual of America | Small Cap Value Fund | 238,561 |
| * | Mutual of America | American Century VP Capital Appreciation Fund | 298,910 |
| * | Mutual of America | Vanguard VIF Diversified Value Portfolio | 197,888 |
| * | Mutual of America | Vanguard VIF International Portfolio | 381,392 |
| * | Mutual of America | American Funds Insurance Series New World Fund | 56,799 |
| * | Mutual of America | Delaware VIP Small Cap Value Series | 60,439 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2024

| (a) | (b) | (c) | (e) |
|---|-----------------------------------|--|---------------------------------------|
| Identity of Issue, Borrower, Lessor or Similar Party | | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2024 |
| | Sub-Accounts of Separate Accounts | of an Insurance Company (continued): | |
| * | Voya | Fidelity VIP Growth Portfolio | \$ 933,767 |
| * | Voya | Large Cap Growth Portfolio | 751,999 |
| * | Voya | Fidelity VIP Contrafund Portfolio | 759,930 |
| * | Voya | Index Plus LargeCap Portfolio | 520,298 |
| * | Voya | Growth and Income Portfolio | 548,542 |
| * | Voya | T. Rowe Price Diversified Mid Cap Growth Portfolio | 517,079 |
| * | Voya | Fidelity VIP Equity-Income Portfolio | 291,094 |
| * | Voya | T. Rowe Price Growth Equity Portfolio | 372,872 |
| * | Voya | Index Plus MidCap Portfolio | 174,019 |
| * | Voya | Large Cap Value Portfolio | 154,936 |
| * | Voya | Invesco Van Kampen V.I. American Franchise | 115,941 |
| * | Voya | Invesco Core Equity | 72,131 |
| * | Voya | Global High Dividend Low Volatility Portfolio | 76,224 |
| * | Voya | Solution 2035 Portfolio | 108,689 |
| * | Voya | Intermediate Bond Portfolio | 48,344 |
| * | Voya | Janus Henderson Enterprise Portfolio | 58,593 |
| * | Voya | American Funds EuroPacific Growth | 47,182 |
| * | Voya | MidCap Opportunities Portfolio | 56,835 |
| * | Voya | Russell Large Cap Index Portfolio | 799 |
| * | Voya | Index Plus SmallCap Portfolio | 47,847 |
| * | Voya | BlackRock Health Science Opportunity Portfolio | 26,988 |
| * | Voya | Janus Henderson Research Portfolio | 50,734 |
| * | Voya | International Index Portfolio Class I | 1,062 |
| * | Voya | American Funds the Growth Fund of America | 37,054 |
| * | Voya | International High Dividend Low Volatility Portfolio | 19,222 |
| * | Voya | Fidelity VIP Overseas Portfolio | 25,819 |
| * | Voya | Small Company Portfolio | 2,196 |
| * | Voya | American Funds Wash Mtual R4 | 20,758 |
| * | Voya | Oppenheimer Global Securities | 23,136 |
| * | Voya | Global Bond Portfolio | 6,039 |
| * | Voya | Janus Henderson VIT Global Research Portfolio | 19,108 |
| * | Voya | Oppenheimer Developing Markets | 4,439 |
| * | Voya | JPMorgan Emerging Markets Equity Portfolio | 9,482 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2024

| (a) | (b) | (c) | (e) |
|--|---------------------------------------|--|---------------------------------------|
| Identity of Issue, Borrower, Lessor or Similar Party | | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2024 |
| Sub-Accounts of Separate Accounts of an Insurance Company (continued): | | | |
| * | Voya | Government Money Market Portfolio | \$ 44,844 |
| * | Voya | Invesco Van Kampen Equity and Income Portfolio | 7,642 |
| * | Voya | Templeton Global Bond Fund | 5,306 |
| * | Voya | Clarion Global Real Estate Portfolio | 2,041 |
| * | Voya | Russell Large Cap Growth Index Portfolio | 6,652 |
| * | Voya | Janus Henderson Balanced Portfolio | 5,430 |
| * | Voya | American Funds New Perspective | 4,061 |
| * | Voya | High Yield Portfolio | 2,446 |
| * | Voya | Pax Sustainable Allocation Fund | 2,305 |
| * | Voya | Pimco Real Return Portfolio | 1,713 |
| * | Voya | SmallCap Opportunities Portfolio | 1,877 |
| * | Voya | Oppenheimer Main Street Small Cap | 1,537 |
| * | Voya | JPMorgan Mid Cap Value Portfolio | 754 |
| * | Voya | JPMorgan Small Cap Core Equity Portfolio | 702 |
| * | Voya | T. Rowe Price Equity Income Portfolio | 624 |
| * | Voya | Solution 2025 Port Srv | 141,751 |
| * | Voya | Solution 2045 Port Srv | 49,789 |
| * | Voya | Solution 2055 Port Srv | 50,121 |
| * | Voya | Solution Aggress Pt I | 52,510 |
| * | Voya | Solution Balanced Pt I | 12,217 |
| * | Voya | Solution Conserv Pt I | 218 |
| * | Voya | Balanced Income Port Ins | 16,807 |
| * | Voya | Glob Insights Port Init | 334,365 |
| * | Voya | Wanger USA | 5,507 |
| | | | 15,780,403 |
| General Account Insurance Investment Contracts: | | | |
| * | Mutual of America | Interest Accumulation Account | 7,192,539 |
| * | Notes receivable from participants | Loans to participants, various maturities, interest rates ranging from 5.28% to 9.50% | 28,719 |
| | | | \$ 29,224,299 |

* Denotes party-in-interest.
Cost information (column (d)) not required due to Plan being participant-directed.

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2023

| (a) | (b) | (c) | (e) |
|---|--|--|-----------|
| Identity of Issue, Borrower, Lessor or Similar Party | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2023 | |
| Mutual Funds: | | | |
| | Blackrock | Mid Cap Growth Equity Fund | \$ 37,544 |
| | Cohen & Steers | Real Estate Securities Fund | 27,855 |
| | Fidelity | NASDAQ Composite Fund | 109,513 |
| | Hood River | Small Cap Growth Fund | 43,380 |
| | MFS | New Discovery Value Fund | 23,557 |
| | Pacific Funds | Floating Rate Income Advisor Fund | 9,931 |
| | Charles Schwab | Personal Choice Retirement Fund | 44,213 |
| | Principal | MidCap Value I R6 | 33,881 |
| | Charles Schwab | Fundamental US Large Company Index Fund | 26,596 |
| | Vanguard | 500 Index Fund | 244,103 |
| | Vanguard | Core Bond Admiral | 31,673 |
| | Vanguard | Global Credit Bond Adm | 21,211 |
| | Vanguard | International Growth Fund | 117,199 |
| | Vanguard | Mid Cap Index Fund | 53,092 |
| | Vanguard | Russell 1000 Growth Index Fund | 176,758 |
| | Vanguard | Small Cap Value Index | 42,705 |
| | Vanguard | Target Retirement 2020 Fund | 97,854 |
| | Vanguard | Target Retirement 2025 Fund | 258,892 |
| | Vanguard | Target Retirement 2030 Fund | 109,765 |
| | Vanguard | Target Retirement 2035 Fund | 275,328 |
| | Vanguard | Target Retirement 2040 Fund | 133,363 |
| | Vanguard | Target Retirement 2045 Fund | 129,082 |
| | Vanguard | Target Retirement 2050 Fund | 480,868 |
| | Vanguard | Target Retirement 2055 Fund | 13,987 |
| | Vanguard | Target Retirement Income Fund | 298,907 |
| | Vanguard | Treasury Money Market Fund | 44,577 |
| | Virtus | Newfleet Multi Sector Short Term Bond Fund | 50,358 |
| | iShares | MSCI EAFE International Index K | 137,475 |
| | | | 3,073,667 |
| Fully Benefit-Responsive Investment Contracts: | | | |
| * | TLIC | Guaranteed Investment Fund Option | 257,833 |
| * | Voya | Fixed Account | 2,289,813 |
| * | Voya | Fixed Plus Account II | 138,853 |
| * | Voya | Fixed Plus Account | 112,369 |
| * | Voya | Long Term GAA | 90,859 |
| * | Voya | Short Term GAA | 4,340 |
| | | | 2,894,067 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2023

| (a) | (b) | (c) | (e) |
|-----|--|--|---------------------------------------|
| | Identity of Issue, Borrower, Lessor or Similar Party | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2023 |
| | Sub-Accounts of Separate Accounts of an Insurance Company (continued): | | |
| * | Mutual of America | Aggressive Allocation | \$ 1,269 |
| * | Mutual of America | Moderate Allocation | 44,164 |
| * | Mutual of America | Bond Fund | 94,769 |
| * | Mutual of America | T. Rowe Price Blue Chip Growth Fund | 28,672 |
| * | Mutual of America | Composite Fund | 419,189 |
| * | Mutual of America | Calvert VP Social Balanced Portfolio | 151,800 |
| * | Mutual of America | Equity Index Fund | 1,660,555 |
| * | Mutual of America | Fidelity VIP Mid Cap Portfolio | 171,309 |
| * | Mutual of America | Fidelity VIP Asset Manager Portfolio | 44,203 |
| * | Mutual of America | Fidelity VIP Contrafund Portfolio | 1,309,037 |
| * | Mutual of America | Fidelity VIP Equity-Income Portfolio | 405,248 |
| * | Mutual of America | Goldman Sachs VIT Small Cap Equity Insights | 73,695 |
| * | Mutual of America | Money Market Fund | 113,835 |
| * | Mutual of America | Mid-Term Bond Fund | 25,550 |
| * | Mutual of America | Mid-Cap Equity Index Fund | 447,871 |
| * | Mutual of America | Mid Cap Value Fund | 44,940 |
| * | Mutual of America | International Fund | 72,467 |
| * | Mutual of America | Oppenheimer Main Street | 611 |
| * | Mutual of America | Retirement Income Fund | 134,360 |
| * | Mutual of America | Vanguard VIF REIT Index Portfolio | 3,477 |
| * | Mutual of America | PIMCO VIT Real Return Portfolio | 165,600 |
| * | Mutual of America | 2025 Retirement Fund | 237,824 |
| * | Mutual of America | 2030 Retirement Fund | 2,225 |
| * | Mutual of America | 2040 Retirement Fund | 250,369 |
| * | Mutual of America | 2045 Retirement Fund | 42,019 |
| * | Mutual of America | All America Fund | 251,712 |
| * | Mutual of America | DWS Capital Growth VIP Fund | 1,240,092 |
| * | Mutual of America | Small Cap Growth Fund | 209,248 |
| * | Mutual of America | Small Cap Value Fund | 235,298 |
| * | Mutual of America | American Century VP Capital Appreciation Fund | 325,923 |
| * | Mutual of America | Vanguard VIF Diversified Value Portfolio | 191,244 |
| * | Mutual of America | Vanguard VIF International Portfolio | 451,451 |
| * | Mutual of America | Vangaurd Total Bond Mkt I Prt | 58,912 |
| * | Mutual of America | American Funds Insurance Series New World Fund | 54,207 |
| * | Mutual of America | Delaware VIP Small Cap Value Series | 55,369 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2023

| (a) | (b) | (c) | (e) |
|---|--|--|------------|
| Identity of Issue, Borrower, Lessor or Similar Party | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2023 | |
| | Sub-Accounts of Separate Accounts of an Insurance Company (continued): | | |
| * | Voya | Fidelity VIP Growth Portfolio | \$ 762,888 |
| * | Voya | Large Cap Growth Portfolio | 627,003 |
| * | Voya | Fidelity VIP Contrafund Portfolio | 633,226 |
| * | Voya | Index Plus LargeCap Portfolio | 484,787 |
| * | Voya | Growth and Income Portfolio | 515,004 |
| * | Voya | T. Rowe Price Diversified Mid Cap Growth Portfolio | 474,656 |
| * | Voya | Fidelity VIP Equity-Income Portfolio | 256,203 |
| * | Voya | T. Rowe Price Growth Equity Portfolio | 291,069 |
| * | Voya | Index Plus MidCap Portfolio | 154,388 |
| * | Voya | Large Cap Value Portfolio | 137,698 |
| * | Voya | Invesco Van Kampen V.I. American Franchise | 117,056 |
| * | Voya | Invesco Core Equity | 73,645 |
| * | Voya | Global High Dividend Low Volatility Portfolio | 64,636 |
| * | Voya | US Bond Index Portfolio Class I | 49,704 |
| * | Voya | Solution 2035 Portfolio | 98,458 |
| * | Voya | Intermediate Bond Portfolio | 45,649 |
| * | Voya | Janus Henderson Enterprise Portfolio | 51,324 |
| * | Voya | American Funds EuroPacific Growth | 45,634 |
| * | Voya | MidCap Opportunities Portfolio | 49,653 |
| * | Voya | Russell Large Cap Index Portfolio | 49,139 |
| * | Voya | Index Plus SmallCap Portfolio | 44,580 |
| * | Voya | BlackRock Health Science Opportunity Portfolio | 31,913 |
| * | Voya | Janus Henderson Research Portfolio | 37,968 |
| * | Voya | International Index Portfolio Class I | 32,397 |
| * | Voya | American Funds the Growth Fund of America | 29,137 |
| * | Voya | International High Dividend Low Volatility Portfolio | 23,153 |
| * | Voya | Fidelity VIP Overseas Portfolio | 24,888 |
| * | Voya | Russell Mid Cap Index Portfolio Class I | 22,116 |
| * | Voya | Small Company Portfolio | 19,226 |
| * | Voya | American Funds Wash Mtual R4 | 17,617 |
| * | Voya | Oppenheimer Global Securities | 20,185 |
| * | Voya | Global Bond Portfolio | 14,099 |
| * | Voya | Balanced Portfolio | 14,992 |
| * | Voya | Janus Henderson VIT Global Research Portfolio | 15,657 |
| * | Voya | Oppenheimer Developing Markets | 12,959 |
| * | Voya | American Century Inflation Adjusted Bond | 10,986 |
| * | Voya | Russell Small Cap Index Portfolio Class I | 13,279 |
| * | Voya | JPMorgan Emerging Markets Equity Portfolio | 9,807 |

APPALACHIAN REGIONAL HEALTHCARE, INC. VOLUNTARY PLAN
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
FORM 5500, SCHEDULE H, PART IV, LINE 4i (CONTINUED)
EIN: 52-0795508, PLAN NUMBER: 005

DECEMBER 31, 2023

| (a) | (b) | (c) | (e) |
|--|---------------------------------------|--|---------------------------------------|
| Identity of Issue, Borrower, Lessor or Similar Party | | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | Current Value December 31, 2023 |
| Sub-Accounts of Separate Accounts of an Insurance Company (continued): | | | |
| * | Voya | Government Money Market Portfolio | \$ 34,333 |
| * | Voya | Strategic Allocation Moderate Portfolio | 10,947 |
| * | Voya | Invesco Van Kampen Equity and Income Portfolio | 9,185 |
| * | Voya | Lord Abbett Short Duration Income Fund | 7,907 |
| * | Voya | Templeton Global Bond Fund | 6,103 |
| * | Voya | Clarion Global Real Estate Portfolio | 5,958 |
| * | Voya | Russell Large Cap Growth Index Portfolio | 5,857 |
| * | Voya | Janus Henderson Balanced Portfolio | 4,764 |
| * | Voya | PIMCO Commodity Real Return Strategy Fund | 2,924 |
| * | Voya | American Funds New Perspective | 3,512 |
| * | Voya | High Yield Portfolio | 2,299 |
| * | Voya | Pax Sustainable Allocation Fund | 2,165 |
| * | Voya | Strategic Allocation Growth Portfolio | 45,977 |
| * | Voya | Pimco Real Return Portfolio | 1,693 |
| * | Voya | SmallCap Opportunities Portfolio | 1,599 |
| * | Voya | Oppenheimer Main Street Small Cap | 1,381 |
| * | Voya | JPMorgan Mid Cap Value Portfolio | 669 |
| * | Voya | JPMorgan Small Cap Core Equity Portfolio | 642 |
| * | Voya | T. Rowe Price Equity Income Portfolio | 565 |
| * | Voya | Strategic Allocation Conservative Portfolio | 203 |
| * | Voya | Solution 2025 Port Srv | 132,214 |
| * | Voya | Solution 2045 Port Srv | 44,121 |
| * | Voya | Solution 2055 Port Srv | 44,109 |
| * | Voya | Glob Insights Port Init | 341,847 |
| * | Voya | Wanger USA | 4,868 |
| | | | 15,111,135 |
| General Account Insurance Investment Contracts: | | | |
| * | Mutual of America | Interest Accumulation Account | 7,772,120 |
| * | Notes receivable from participants | Loans to participants, various maturities, interest rates ranging from 5.28% to 9.50% | 39,333 |
| | | | \$ 28,890,322 |

* Denotes party-in-interest.
Cost information (column (d)) not required due to Plan being participant-directed.

Schedule C, Line 2(h) Formula Descriptions

Appalachian Regional Healthcare, Inc. Voluntary Plan

EIN No.: 52-0795508, Plan No. 005

Plan Year Ending: 12/31/2024

Indirect Compensation in the form of revenue sharing was paid to the following Service Providers:

| | |
|-----------------------------------|------------|
| TRANSAMERICA RETIREMENT SOLUTIONS | 13-3689044 |
| NATIONAL FINANCIAL SERVICES | 04-3523567 |

Revenue amounts are shown in annualized basis points of plan assets invested in applicable fund

| Fund Family | Fund Name | Start Date | End Date | Revenue to Transamerica Retirement Solutions | Revenue to National Financial Services |
|----------------|---|------------|------------|--|--|
| ARISTOTLE | ARISTOTLE FLOATING RATE INCOME I2 | 1/1/2024 | 12/31/2024 | 9.670 | 0.330 |
| BLACKROCK | BLACKROCK MID-CAP GROWTH EQUITY INSTL | 1/1/2024 | 8/1/2024 | 24.175 | 0.825 |
| COHEN & STEERS | COHEN & STEERS REAL ESTATE SECURITIES I | 1/1/2024 | 12/31/2024 | 9.670 | 0.330 |
| HOOD RIVER | HOOD RIVER SMALL CAP GROWTH INSTL | 1/1/2024 | 12/31/2024 | 11.604 | 0.396 |
| VIRTUS | VIRTUS NEWFLEET MULTI-SECTOR ST BOND I | 1/1/2024 | 12/31/2024 | 24.175 | 0.825 |

**ATTACHMENT TO THE 2024 SCHEDULE H OF FORM 5500
LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR)**

Plan Sponsor: Appalachian Regional Healthcare, Inc.

Plan Name: Appalachian Regional Healthcare, Inc. Voluntary Plan

Plan Year: July 1, 2024 to December 31, 2024

EIN: 52-0795508

Plan No.: 005

Item 4i- Schedule of Assets Held at End of Year

Page 13-20 of the attached auditor's report of the Plan for the plan year ending December 31, 2024 provides the schedule of assets information.