

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

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

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, a single-employer plan, a DFE, etc.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report, etc.
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, etc.
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

1a Name of plan: CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST
1b Three-digit plan number (PN): 333
1c Effective date of plan: 01/01/1998
2a Plan sponsor's name, mailing address, city, state, and ZIP: CENTRAL ARKANSAS NURSING CENTERS, INC., 415 ROGERS AVENUE, FORT SMITH, AR 72901-1903
2b Employer Identification Number (EIN): 71-0694879
2c Plan Sponsor's telephone number: 479-783-4672
2d Business code (see instructions): 561110

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

| | | |
|---|--|------|
| 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 | 5864 |
| 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) | 5591 |
| | 6a(2) | 5226 |
| | 6b | 23 |
| | 6c | 215 |
| | 6d | 5464 |
| | 6e | 0 |
| | 6f | 5464 |
| | 6g(1) | 1157 |
| 6g(2) | 908 | |
| 6h | 224 | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | |

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

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

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

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

a Pension Schedules

- (1) **R** (Retirement Plan Information)
- (2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) **DCG** (Individual Plan Information) – Number Attached _____
- (5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) **H** (Financial Information)
- (2) **I** (Financial Information – Small Plan)
- (3) **A** (Insurance Information) – Number Attached 1
- (4) **C** (Service Provider Information)
- (5) **D** (DFE/Participating Plan Information)
- (6) **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

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

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

| | | |
|---|---|--|
| <p>A Name of plan CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>333</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 CENTRAL ARKANSAS NURSING CENTERS, INC.</p> | <p>D Employer Identification Number (EIN) 71-0694879</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
NATIONWIDE 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 |
| 31-4156830 | 66869 | GAP-CP-GE8B | 908 | 01/01/2024 | 12/31/2024 |

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

| | |
|---|---|
| <p>(a) Total amount of commissions paid 2206</p> | <p>(b) Total amount of fees paid 0</p> |
|---|---|

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

WELLS FARGO ADVISORS, LLC 1 N JEFFERSON AVE
9TH FL
SAINT LOUIS, MO 63103-1207

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-----------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1834 | 0 | COMMISSION PAID | 3 |

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

RAYMOND JAMES & ASSOCIATES INC. PO BOX 14527
ST PETERSBURG, FL 33733-4527

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-----------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 372 | 0 | COMMISSION PAID | 3 |

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

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

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

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (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 599343 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 5 11691904 |
| 6 | Contracts With Allocated Funds: | |
| a | State the basis of premium rates ▶ | |
| b | Premiums paid to carrier | 6b |
| c | Premiums due but unpaid at the end of the year | 6c |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶ | 6d |
| e | Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | |
| f | If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | |
| 7 | Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | |
| a | Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input checked="" type="checkbox"/> other ▶ GIC | |
| b | Balance at the end of the previous year | 7b 475301 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) 77129 |
| | (2) Dividends and credits..... | 7c(2) 129 |
| | (3) Interest credited during the year..... | 7c(3) 9091 |
| | (4) Transferred from separate account | 7c(4) 2264042 |
| | (5) Other (specify below)..... | 7c(5) 2852 |
| | ▶ OTHER ADDITIONS | |
| (6) Total additions | 7c(6) 2353243 | |
| d | Total of balance and additions (add lines 7b and 7c(6)) | 7d 2828544 |
| e | Deductions: | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) 66375 |
| | (2) Administration charge made by carrier..... | 7e(2) 4310 |
| | (3) Transferred to separate account | 7e(3) 2154062 |
| | (4) Other (specify below)..... | 7e(4) 4454 |
| ▶ OTHER DEDUCTIONS | | |
| (5) Total deductions | 7e(5) 2229201 | |
| f | Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f 599343 |

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

| | | |
|--|--|------------|
| A Name of plan CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST | B Three-digit plan number (PN) ▶ | 333 |
| C Plan sponsor's name as shown on line 2a of Form 5500 CENTRAL ARKANSAS NURSING CENTERS, INC. | D Employer Identification Number (EIN) 71-0694879 | |

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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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)

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 15 64 | RECORD-KEEPER | 86741 | 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)

WELLS FARGO ADVISORS, LLC

1 N JEFFERSON AVE
9TH FL
SAINT LOUIS, MO 63103

34-1542819

| (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? |
|------------------------|---|--|--|--|---|--|
| 27 28 52 | INVESTMENT MANAGER | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 38069 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

DEFINITI LLC

2201 TIMBERLOCH PL
STE 150
THE WOODLANDS, TX 77380

85-0833363

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | THIRDPARTY ADMINISTRATOR | 33325 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

RAYMOND JAMES & ASSOC INC

PO BOX 14527
ST PETERSBURG, FL 33733-4527

59-1199408

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 14 | CONTRACT ADMINISTRATOR | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 6032 | 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"/> |

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

| | | |
|--|--|--|
| SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | <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 CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST | B Three-digit plan number (PN) ▶ 333 |
| C Plan sponsor's name as shown on line 2a of Form 5500 CENTRAL ARKANSAS NURSING CENTERS, INC. | D Employer Identification Number (EIN) 71-0694879 |

| | |
|---------------|--------------------------------------|
| 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) | 160006 | 145540 |
| (2) Participant contributions | 1b(2) | 24015 | 60039 |
| (3) Other | 1b(3) | | |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | | |
| (2) U.S. Government securities | 1c(2) | | |
| (3) Corporate debt instruments (other than employer securities): | | | |
| (A) Preferred | 1c(3)(A) | | |
| (B) All other | 1c(3)(B) | | |
| (4) Corporate stocks (other than employer securities): | | | |
| (A) Preferred | 1c(4)(A) | | |
| (B) Common | 1c(4)(B) | | |
| (5) Partnership/joint venture interests | 1c(5) | | |
| (6) Real estate (other than employer real property) | 1c(6) | | |
| (7) Loans (other than to participants) | 1c(7) | | |
| (8) Participant loans | 1c(8) | | |
| (9) Value of interest in common/collective trusts | 1c(9) | | |
| (10) Value of interest in pooled separate accounts | 1c(10) | | |
| (11) Value of interest in master trust investment accounts | 1c(11) | | |
| (12) Value of interest in 103-12 investment entities | 1c(12) | | |
| (13) Value of interest in registered investment companies (e.g., mutual funds) | 1c(13) | 10095782 | 11691904 |
| (14) Value of funds held in insurance company general account (unallocated contracts)..... | 1c(14) | 478469 | 599343 |
| (15) Other..... | 1c(15) | | |

| 1d Employer-related investments: | | (a) Beginning of Year | (b) End of Year |
|--|--------------|-----------------------|-----------------|
| (1) Employer securities..... | 1d(1) | | |
| (2) Employer real property..... | 1d(2) | | |
| e Buildings and other property used in plan operation..... | 1e | | |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 10758272 | 12496826 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | | |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | | |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 0 | 0 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 10758272 | 12496826 |

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) | 145540 | |
| (B) Participants..... | 2a(1)(B) | 1773141 | |
| (C) Others (including rollovers)..... | 2a(1)(C) | 124415 | |
| (2) Noncash contributions..... | 2a(2) | | |
| (3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2) | 2a(3) | | 2043096 |
| 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) | | |
| (F) Other..... | 2b(1)(F) | | |
| (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | | 0 |
| (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) | | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 0 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | | |

| | | (a) Amount | (b) Total |
|---|---------------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts | 2b(6) | | |
| (7) Net investment gain (loss) from pooled separate accounts | 2b(7) | | |
| (8) Net investment gain (loss) from master trust investment accounts | 2b(8) | | |
| (9) Net investment gain (loss) from 103-12 investment entities | 2b(9) | | |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) | 2b(10) | | 1161082 |
| c Other income | 2c | | 6826 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 3211004 |

Expenses

| | | | |
|---|---------------|---------|---------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 1407342 | |
| (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) | | 1407342 |
| 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) | 33325 | |
| (3) Recordkeeping fees | 2i(3) | 31783 | |
| (4) IQPA audit fees | 2i(4) | | |
| (5) Investment advisory and investment management fees | 2i(5) | | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | | |
| (7) Actuarial fees | 2i(7) | | |
| (8) Legal fees | 2i(8) | | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses | 2i(11) | | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 65108 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 1472450 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 1738554 |
| 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: **LITTLE, SHANEYFELT, MARSHALL & CO.**

(2) EIN: **71-0804806**

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.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 53214 |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| e Was this plan covered by a fidelity bond? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 500000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| l Has the plan failed to provide any benefit when due under the plan? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> | |

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. | OMB No. 1210-0110 2024 This Form is Open to Public Inspection. |
|--|---|--|

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

| | | |
|--|--|------------|
| A Name of plan <u>CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST</u> | B Three-digit plan number (PN) ▶ | <u>333</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>CENTRAL ARKANSAS NURSING CENTERS, INC.</u> | D Employer Identification Number (EIN) <u>71-0694879</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 | <u>0</u> |
|---|----------|----------|

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): 31-1592130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part VII IRS Compliance Questions

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

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

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q703785A.

| | | |
|---|--|---|
| SCHEDULE MEP (Form 5500) <small>Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration</small> | MULTIPLE-EMPLOYER RETIREMENT PLAN INFORMATION This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and Section 6058(a) of the Internal Revenue Code (the Code) ▶ File as an attachment to Form 5500. | OMB No. 1210-0110 2024 This Form is Open to Public Inspection |
|---|--|---|

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

| | | |
|---|---|------------|
| A Name of plan CENTRAL ARKANSAS NURSING CENTERS, INC. 401(K) PLAN AND TRUST | B Three-digit Plan number (PN)..... ▶ | 333 |
| C Plan administrator's name as shown on line 3a of Form 5500/Form 5500-SF CENTRAL ARKANSAS NURSING CENTERS, INC. | D Administrator's EIN 71-0694879 | |

Part I Type of Multiple-Employer Pension Plan. All multiple-employer pension plans must complete.

1 Check the appropriate box to indicate type of multiple-employer pension plan. (Only defined contribution plans may check lines 1a, 1b, and 1c. Defined benefit plans and defined contribution plans not checking lines 1a, 1b, or 1c should check line 1d. See Instructions).

- a** association retirement plan (See 29 CFR 2510.3-55) (Complete Part II)
- b** professional employer organization plan (PEO Plan) (See 29 CFR 29 CFR 2510.3-55) (Complete Part II)
- c** pooled employer plan (PEP) (See 29 CFR 2510.3-44) (Complete Parts II and III)
- d** other multiple-employer pension plan (Describe) _____ (Complete Part II)

Part II Participating Employer Information.

2 All multiple-employer pension plans that are subject to section 210(a) of ERISA (see instructions for filing the Form 5500) must complete Part II, in addition to Part I, in accordance with the instructions, to report the information for each employer participating in the multiple-employer pension plan. **Defined contribution plans must complete lines 2a-2d. All other multiple-employer pension plans complete lines 2a-2c only. Complete as many entries as needed to list the required information for each participating employer that is not an individual person (see instructions).**

| | | | |
|---|------------------------------------|--|--|
| 2a Name of Participating Employer ALMA NURSING & REHAB LLC | 2b EIN 85-3032310 | 2c Percentage of Total Contributions for the Plan Year 2.45 | 2d Aggregate Account Balances Attributable to Participating Employer 138733 |
| 2a Name of Participating Employer APPLE CREEK HEALTH AND REHAB | 2b EIN 46-5082228 | 2c Percentage of Total Contributions for the Plan Year 2.52 | 2d Aggregate Account Balances Attributable to Participating Employer 109983 |

CAUTION Do not individually list information for working owners (see instructions and 29 CFR 2510.3-55(d)(2)) or other individuals who are participants or beneficiaries in the plan or arrangement that are no longer associated with a particular participating employer or participating employer plan (see instructions). Providing identifying information for individuals may result in rejection of this filing. If there are any such individuals in the plan, answer "Yes" to line 2e and provide the total information for all such individuals, without providing names or other identifying information.

| | | |
|--|-----------|---|
| 2e Does the plan include any individuals not participating through an employer or who are individual working owners? | 2e | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 2f If you answer "Yes" in line 2e, enter a good faith estimate of the percentage of total contributions made by all such individuals that are not listed on line 2a during the plan year. | 2f | |
| 2g If you answer "Yes" in Line 2e, enter the aggregate account balances for all such individuals that are not listed on line 2a. | 2g | |

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

**Schedule MEP (2024)
v. 240311**

Part II Participating Employer Information (Continued).

Use this page for additional participating employer information.

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Defined contribution plans must complete lines 2a-2d. All other multiple-employer pension plans complete lines 2a-2c only. Complete as many entries as needed to list the required information for each participating employer that is not an individual person (see instructions).

| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|--|------------|--|--|
| ASHTON PLACE HEALTH AND REHAB, LLC | 27-4595185 | 2.87 | 176633 |
| ASPEN HEALTH AND REHAB | 86-1120646 | 1.83 | 110863 |
| ATKINS NURSING AND REHABILITATION CENTER, INC. | 22-3928953 | 1.83 | 267824 |
| BELVEDERE NURSING AND REHABILITATION, LLC | 47-3431331 | 2.97 | 160888 |
| BRADFORD HOUSE NURSING AND REHAB, LLC | 27-4398380 | 1.62 | 194717 |
| BRIARWOOD NURSING AND REHABILITATION CENTER, INC | 20-3697298 | 0.95 | 155146 |
| CABOT HEAL TH REHAB, LLC | 47-1951112 | 2.17 | 94665 |
| CENTRAL ARKANSAS NURSING CENTERS, INC. | 71-0694879 | 4.03 | 1814144 |
| CHAPEL RIDGE NURSING CENTER, LLC | 81-3667791 | 2.04 | 211911 |

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Part II Participating Employer Information (Continued).

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|--|------------|--|--|
| CHEROKEE MANOR NURSING AND REHABILITATION CENTER, INC. | 20-3697211 | 1.57 | 432425 |
| CLEARVIEW DIGITAL IMAGE, LLC | 82-2559421 | 4.54 | 464009 |
| COLONEL GLENN HEALTH AND REHAB, LLC | 47-3064280 | 0.30 | 5962 |
| COUNTRY CLUB GARDENS, LLC DBA LAKE HAMILTON HEALTH AND REHAB | 26-1385472 | 1.21 | 91999 |
| DARDANELLE NURSING AND REHABILITATION CENTER, INC. | 22-3928955 | 1.89 | 636246 |
| EUFAULA MANOR NURSING AND REHABILITATION CENTER, INC. | 86-1120644 | 0.32 | 6504 |
| EXACTA LABORATORY SYSTEMS, LLC | 83-3547008 | 0.82 | 40622 |
| GARRETT WOODS ASSISTED LIVING, LLC | 81-2623800 | 0.55 | 12429 |
| GREENBRIER NURSING AND REHABILITATION CENTER, INC | 84-1715232 | 0.69 | 96097 |

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Part II Participating Employer Information (Continued).

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|---|------------|--|--|
| GREYSTONE NURSING AND REHAB, LLC | 27-3982663 | 0.88 | 139231 |
| GROUP PURCHASING ADVANTAGE, INC. | 71-0645264 | 2.10 | 229836 |
| HAMPTON PLACE HEALTHCARE, LLC | 92-2333309 | 0.18 | 7251 |
| HEATHER MANOR NURSING AND REHABILITATION CENTER, INC. | 86-1120643 | 2.45 | 338404 |
| HICKORY HEIGHTS HEALTH AND REHAB, LLC | 46-4017764 | 0.65 | 49817 |
| HIGHLANDS OF BELLA VISTA HEALTH & REHAB, LLC | 85-3073161 | 2.54 | 200780 |
| INNISFREE HEALTH AND REHAB, LLC | 27-4398509 | 1.14 | 86075 |
| JACKSONVILLE CARE CENTER, LLC | 47-1981528 | 0.01 | 118 |
| JAMESTOWN NURSING AND REHAB, LLC | 27-4398447 | 3.47 | 169667 |

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Part II Participating Employer Information (Continued).

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|---|------------|--|--|
| JOHNSON COUNTY HEALTH AND REHAB, LLC | 46-2384815 | 2.29 | 209454 |
| LAKEWOOD HEALTH AND REHAB, LLC | 47-1930617 | 1.04 | 72406 |
| LEGACY HEIGHTS NURSING AND REHAB, LLC | 45-2349042 | 3.60 | 300543 |
| LONOKE HEALTH AND REHAB, LLC | 47-1917588 | 0.20 | 10768 |
| MALLARD EQUIPMENT SUPPLY, LLC | 47-2251335 | 0.17 | 8056 |
| MALLARD MEDICAL SUPPLY, LLC | 46-3692098 | 2.32 | 228607 |
| NPMC HOME HEALTH, LLC DBA TRINITY CENTRAL HOME HEALTH, LLC | 20-8449844 | 2.62 | 85617 |
| NURSING AND REHABILITATION AT GOOD SHEPHERD, LLC | 71-0862133 | 1.09 | 55005 |
| NURSING CONSULTANTS, INC. | 71-0826468 | 5.41 | 1065861 |

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Part II Participating Employer Information (Continued).

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|--|------------|--|--|
| OAK MANOR NURSING AND REHABILITATION CENTER, INC. | 22-3928956 | 1.03 | 770757 |
| PERRY COUNTY NURSING AND REHABILITATION CENTER, INC. | 86-1120641 | 1.93 | 403672 |
| PREMIER PHARMACY CARE, LLC | 46-5611930 | 14.24 | 1376272 |
| QUAPAW CARE AND REHABILITATION CENTER, LLC | 01-0707431 | 1.95 | 357723 |
| QUEST TRANSPORTATION, LLC | 81-4704790 | 0.55 | 9103 |
| ROBINSON NURSING AND REHABILITATION CENTER, LLC | 71-0862118 | 0.45 | 46452 |
| RUSSELLVILLE NURSING AND REHABILITATION CENTER, INC. | 22-3928951 | 0.63 | 69140 |
| SALEM PLACE NURSING AND REHABILITATION CENTER, INC. | 20-3697215 | 2.04 | 106251 |
| SHERWOOD NURSING AND REHABILITATION CENTER, INC. | 03-0398609 | 0.25 | 75920 |

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Part II Participating Employer Information (Continued).

Use this page for additional participating employer information.

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|--|------------|--|--|
| SHILOH NURSNG AND REHAB, LLC | 27-4398302 | 2.12 | 93199 |
| STELLA MANOR NURSING AND REHABILITATION CENTER, INC. | 20-3697322 | 1.17 | 65266 |
| SUPERIOR HEALTH & REHAB, LLC | 83-3275142 | 0.68 | 86392 |
| TRINITY NORTH HOME HEALTH, LLC | 88-4013818 | 0.81 | 21322 |
| TRINITY RIVER VALLEY HOME HEALTH LLC | 46-2961555 | 1.31 | 43343 |
| ARBOR HOSPICE AND PALLIATIVE CARE, LLC | 99-4947683 | 0.01 | 253 |
| TRINITY HOME HEALTH OF SOUTHERN ARKANSAS, LLC | 99-4962668 | 0.00 | 0 |
| ASHTON ACRES, LLC | 81-4118137 | 0.00 | 0 |
| STRATEGIC ADVISORY | 93-4459547 | 0.87 | 40489 |

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Part II Participating Employer Information (Continued).

Use this page for additional participating employer information.

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| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
|-----------------------------------|------------|--|--|
| BROOKEN HILL HEALTH & REHAB | 92-2805882 | 0.67 | 201695 |
| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
| 2a Name of Participating Employer | 2b EIN | 2c Percentage of Total Contributions for the Plan Year | 2d Aggregate Account Balances Attributable to Participating Employer |
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| | |
|-----------------|---|
| Part III | Pooled Employer Plan Information |
|-----------------|---|

Line 3. All Pooled employer plans must answer all of the questions in Part III, in addition to completing all of Parts I and II.

3a Is the pooled plan provider (identified as the plan sponsor and administrator in Part II of the Form 5500) currently in compliance with the Form PR (Pooled Plan Provider Registration Statement) requirements? (See instructions and 29 CFR 2510.3-44)..... Yes No

3b If line 3a is "Yes", enter the ACK ID for the most recent Form PR that was required to be filed under the Form PR filing requirements. (Failure to enter a valid ACK ID will subject the Form 5500 filing to rejection as incomplete.)
ACK ID _____

**CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST**

**FINANCIAL STATEMENTS AND
SUPPLEMENTAL INFORMATION**

**As of December 31, 2024 and 2023 and
for the Year Ended December 31, 2024**



**CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST**

CONTENTS OF REPORT

| | PAGE |
|---|-------------|
| Independent auditor's report | 1 - 3 |
| Financial statements: | |
| Statements of net assets available for benefits | 4 |
| Statement of changes in net assets available for benefits | 5 |
| Notes to financial statements | 6 - 9 |
| Supplemental information: | |
| Schedule of assets (held at end of year) | 10 – 14 |
| Schedule of delinquent participant contributions | 15 |



Independent Auditor's Report

To the Administrative Committee of the
Central Arkansas Nursing Centers, Inc. 401(k) Plan and Trust

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

We have performed audits of the financial statements of Central Arkansas Nursing Centers, Inc. 401(k) Plan and Trust (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statement of net assets available for benefits as of December 31, 2024 and 2023, and the related statement of changes in net assets available for benefits for the year ended December 31, 2024, and the related notes to the financial statements.

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

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

Opinion

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

- the amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- the information in the accompanying financial statements 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 (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

Our audit 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 schedule of assets and schedule of delinquent participant contributions as of the year ended December 31, 2024, are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, have been subjected to auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. For information included in the supplemental 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 the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion

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

Little, Shaneyfelt, Marshall & Co.

Little, Shaneyfelt, Marshall & Co.

January 16, 2026

**CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST**

**FINANCIAL STATEMENTS AND
SUPPLEMENTAL INFORMATION**

**As of December 31, 2024 and 2023 and
for the Year Ended December 31, 2024**



**CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST**

CONTENTS OF REPORT

| | PAGE |
|---|-------------|
| Independent auditor's report | 1 - 3 |
| Financial statements: | |
| Statements of net assets available for benefits | 4 |
| Statement of changes in net assets available for benefits | 5 |
| Notes to financial statements | 6 - 9 |
| Supplemental information: | |
| Schedule of assets (held at end of year) | 10 – 14 |
| Schedule of delinquent participant contributions | 15 |

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2024 and 2023

| | <u>2024</u> | <u>2023</u> |
|--|----------------------|----------------------|
| ASSETS | | |
| INVESTMENTS - FAIR VALUE | | |
| Mutual funds | \$ 11,691,904 | \$ 10,095,782 |
| INVESTMENTS - CONTRACT VALUE | | |
| Nationwide Fixed Select Contract | 599,343 | 478,469 |
| RECEIVABLES | | |
| Participant contributions | 60,039 | 24,015 |
| Employer contributions | 145,540 | 160,006 |
| Total receivables | <u>205,579</u> | <u>184,021</u> |
| TOTAL ASSETS | <u>12,496,826</u> | <u>10,758,272</u> |
| LIABILITIES AND NET ASSETS AVAILABLE FOR BENEFITS | | |
| LIABILITIES | | |
| Accounts payable | - | - |
| TOTAL LIABILITIES | <u>-</u> | <u>-</u> |
| NET ASSETS AVAILABLE FOR BENEFITS | <u>\$ 12,496,826</u> | <u>\$ 10,758,272</u> |

See accompanying notes.

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Year Ended December 31, 2024

ADDITIONS TO NET ASSETS ATTRIBUTED TO:

INVESTMENT INCOME

| | |
|---|------------------|
| Net appreciation in fair value of investments | \$ 1,158,361 |
| Dividends and interest | 2,721 |
| Net investment gain | <u>1,161,082</u> |

CONTRIBUTIONS

| | |
|---------------------|------------------|
| Participant | 1,773,141 |
| Employer | 145,540 |
| Rollover | 124,415 |
| Total contributions | <u>2,043,096</u> |

OTHER

| | |
|-----------------------------------|--------------|
| Lost earnings restorative payment | <u>6,826</u> |
|-----------------------------------|--------------|

| | |
|-----------------|------------------|
| Total additions | <u>3,211,004</u> |
|-----------------|------------------|

DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:

| | |
|-------------------------------|------------------|
| Benefits paid to participants | 1,407,342 |
| Administration expenses | 65,108 |
| Total deductions | <u>1,472,450</u> |

| | |
|---------------------|-----------|
| NET INCREASE | 1,738,554 |
|---------------------|-----------|

| | |
|---|-------------------|
| NET ASSETS AVAILABLE FOR BENEFITS, BEGINNING OF YEAR | <u>10,758,272</u> |
|---|-------------------|

| | |
|---|-----------------------------|
| NET ASSETS AVAILABLE FOR BENEFITS, END OF YEAR | <u><u>\$ 12,496,826</u></u> |
|---|-----------------------------|

See accompanying notes.

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
NOTES TO FINANCIAL STATEMENTS
December 31, 2024 and 2023

Note 1 - Description of Plan

The following description of the Central Arkansas Nursing Centers, Inc. (the Company) 401(k) Plan and Trust (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 Central Arkansas Nursing Centers, Inc. 401(k) Plan and Trust is a defined contribution plan. Participants in the Plan are employees of the Company who are age eighteen or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions - Each year, participants may contribute a discretionary amount of pretax annual compensation, as defined by the Plan. The amount that can be contributed is set by law each year and was limited to \$22,500 for the year ended December 31, 2024. Participants age 50 or over may contribute an additional amount, known as a "catch-up" contribution, limited to \$7,500 for the year ended December 31, 2024. Participants may also contribute amounts representing distributions from other qualified defined contribution or defined benefit plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Company makes discretionary matching contributions which are also invested at the participants' discretion. Additional profit sharing amounts may be contributed at the discretion of the Company's board of directors and are invested in the same manner as the matching contributions. Discretionary company contributions are subject to certain limitations as set by law.

Participant Accounts - Each participant's account is credited with the participant's contribution, the Company's matching contribution, and Plan earnings net of expenses. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting - Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in the Company's contribution portion of their accounts plus actual earnings thereon is based on years of continuous service. A participant is 100% vested after six years of credited service, with the participant vesting 20% per year of service beginning with the second year of service.

Payment of Benefits - On termination of service due to death, disability, or retirement, or other reasons, 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. Hardship withdrawals of employee contributions are also permitted, subject to IRS provisions.

Forfeited Accounts - Forfeited nonvested accounts totaled \$75,358 and \$37,754 as of December 31, 2024 and 2023, respectively. These accounts may be used to reduce future employer contributions. During the year ended December 31, 2024, employer contributions were not reduced by forfeited nonvested accounts.

Note 2 - Summary of Significant Accounting Policies

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

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Investment Valuation and Income Recognition - 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. See Note 4 for discussion of fair value measurements.

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

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
NOTES TO FINANCIAL STATEMENTS
December 31, 2024 and 2023

Note 2 - Summary of Significant Accounting Policies (Continued)

Payment of Benefits - Benefits are recorded when paid.

Expenses - The Plan's expenses are paid either by the Plan or the Company, as provided by the plan document. Expenses that are paid directly by the Company are excluded from these financial statements. Certain expenses incurred in connection with the general administration of the Plan that are paid by the Plan are recorded as deductions in the accompanying statement of changes in net assets available for benefits.

Note 3 - Investment in Nationwide Fixed Select Contract

The Plan is invested in the Nationwide Fixed Select Contract which is a group annuity contract invested in assets held in Nationwide Life Insurance Company's general account. The contract's main characteristic is that it allows for principal value and accrued income to remain stable regardless of fluctuations in market interest rates or the price of underlying assets.

As described in Note 2, because the Nationwide Fixed Select Contract is a fully benefit responsive investment contract, contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the Nationwide Fixed Select Contract. Contract value, as reported to the Plan by the Nationwide Fixed Select Contract, represents the results of operations for the reporting period and net assets held at the reporting date.

Note 4 - Fair Value Measurement

The Plan's investments are reported at fair value in the accompanying statements of net assets available for benefits.

The Plan utilizes an accounting standard for fair value measurement, which establishes a framework for measuring fair value and expands disclosures about fair value measurements.

The standard defines fair value as 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. The standard also establishes a fair value hierarchy that requires the use of observable inputs and minimizes the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

- Level 1 Inputs - Quoted prices in active markets for individual assets or liabilities.
- Level 2 Inputs - Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities in active markets; quoted prices for similar assets or liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 Inputs - Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. The inputs used for valuing assets are not an indication of the risk associated with investing in those assets.

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
NOTES TO FINANCIAL STATEMENTS
December 31, 2024 and 2023

Note 4 - Fair Value Measurement (continued)

Financial assets and liabilities measured at fair value on a recurring basis include the following:

Mutual Funds - Investments in mutual funds are valued at quoted net asset values of the shares as reported by the fund and are categorized within Level 1 of the fair value hierarchy. The mutual funds held by the Plan are open-ended mutual funds registered with the U.S. Securities and Exchange Commission. The funds must publish their daily net asset value and transact at that price. The mutual funds held by the Plan are considered to be actively traded.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023.

| | | <u>Fair Value Measurements at Reporting Date Using:</u> | | | |
|--------------------------|---------------------|---|---|--|--|
| | | <u>Fair Value</u> | <u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u> | <u>Significant Other Observable Inputs (Level 2)</u> | <u>Significant Unobservable Inputs (Level 3)</u> |
| <u>December 31, 2024</u> | | | | | |
| Mutual funds | <u>\$11,691,904</u> | <u>\$11,691,904</u> | <u>\$ 0</u> | <u>\$ 0</u> | |
| <u>December 31, 2023</u> | | | | | |
| Mutual funds | <u>\$10,095,782</u> | <u>\$10,095,782</u> | <u>\$ 0</u> | <u>\$ 0</u> | |

Note 5 - Information Prepared and Certified by the Investment Custodian

The following information included in the accompanying financial statements, Note 4, and the supplemental schedule, was obtained from data that has been prepared and certified to as complete and accurate by the investment custodian.

| | <u>2024</u> | <u>2023</u> |
|---|---------------------|---------------------|
| Investments, at fair value (participant - directed) | <u>\$11,691,904</u> | <u>\$10,095,782</u> |
| Investments, at contract value (participant - directed) | <u>\$ 599,343</u> | <u>\$ 478,469</u> |
| Net appreciation in fair value of investments | <u>\$ 1,158,361</u> | |
| Dividends and interest | <u>\$ 2,721</u> | |

Note 6 - Plan Termination

Although it has not expressed any intent to do so, the Trustees have the right under the Plan to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants would receive the full amount in their individual accounts after all Plan expenses are paid as of the date of termination.

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
NOTES TO FINANCIAL STATEMENTS
December 31, 2024 and 2023

Note 7 - Tax Status

The IRS has determined and informed the plan sponsor by a letter dated March 31, 2014, that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). The Plan has been amended since receiving the determination letter. However, the Plan's administrator believes that the Plan is designed and currently being operated in compliance with the applicable requirements of the IRC. Accounting principles generally accepted in the United States require the plan administrator 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 IRS. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that, as of December 31, 2024, there are no uncertain 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 tax authorities; however, there are currently no audits in progress for any tax periods.

Note 8 - Risks and Uncertainties

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

Note 9 - Concentration of Credit Risk

The Plan invests in mutual funds held by Nationwide Financial Services, Inc. (Nationwide). The Plan does not require collateral other than SIPC insurance or certain bonding requirements required by regulatory agencies.

Note 10 - Administration Expenses

Administration expenses consist of the following:

| | |
|--|-----------------|
| Nationwide asset fee | \$31,250 |
| Nationwide advisory and service provider fee | 31,741 |
| Nationwide trust/custodial fee | 250 |
| Definiti third party administrator fees | <u>1,867</u> |
| | <u>\$65,108</u> |

Note 11 - Party-In-Interest Transactions

Nationwide is the investment custodian and administrative service provider to the Plan. Administration expenses paid to Nationwide were \$63,241 for the year ended December 31, 2024.

Definiti, Inc. is a third-party administrator for the Plan. Administration expenses paid to Definiti, Inc. were \$1,867 for the year ended December 31, 2024.

Note 12 - Delinquent Participant Contributions

During the year ended December 31, 2024, certain participant contributions were not remitted to the Plan's trust within the timeframe established by the DOL. As of December 31, 2024, the Plan recorded a receivable of \$60,039 in the Statement of Net Assets Available for Benefits. Subsequent to year-end, the Plan sponsor remitted the delinquent principal amounts totaling \$53,213. However, as of the date of the independent auditor's report, the calculated lost earnings of \$6,826 remain unremitted. The Plan sponsor intends to deposit these earnings and file Form 5330 with the IRS to pay the associated excise taxes.

Note 13 - Subsequent Events

Subsequent events were evaluated through January 16, 2026, which is the date the financial statements were available to be issued.

SUPPLEMENTAL INFORMATION

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
EIN 71-0694879
PLAN NUMBER 333
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS
(HELD AT END OF YEAR)
December 31, 2024

| (a) Party-in Interest | (b) Identity of Issue, Borrower, Lessor or Similar Party | (c) Description of investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|-----------------------------|--|---|-------------|-------------------------|
| * | Nationwide Financial Services, Inc. | Fixed Select Contract | ** | \$ 599,343 |
| | Ab Gbl Bd I | Mutual Fund | ** | 2,340 |
| | Ab Global Bond Fund Class Z | Mutual Fund | ** | 100,326 |
| | Aqr Eq Mkt Nutrl I | Mutual Fund | ** | 40,421 |
| | Aqr Lng Shrt Eq I | Mutual Fund | ** | 26,749 |
| | Alger Smcap Focs Y | Mutual Fund | ** | 43,561 |
| | Amara Partcptn Inst | Mutual Fund | ** | 6,920 |
| | Ambcn Intl Eq R5 | Mutual Fund | ** | 973 |
| | Amcent Eq Inc I | Mutual Fund | ** | 241,387 |
| | Amcent Mdcap Val R6 | Mutual Fund | ** | 2,248 |
| | Amcent Shtdrinfprtbd R5 | Mutual Fund | ** | 74 |
| | Amfds Bd Fd Am R6 | Mutual Fund | ** | 250,524 |
| | Amfds New Wild R6 | Mutual Fund | ** | 13,467 |
| | Avantis Emerging Markets Equity Fund | Mutual Fund | ** | 252,342 |
| | Avnts Us Lgcap Val Inst | Mutual Fund | ** | 301,292 |
| | Avnts Us Smcap Val Inst | Mutual Fund | ** | 86,089 |
| | Blkrk Hi Yld Bd Port K | Mutual Fund | ** | 204,736 |
| | BlkRk iSMSCIEAFElntnd K | Mutual Fund | ** | 1,266 |
| | Blkrk Mdcap Gr Eq Inst | Mutual Fund | ** | 658 |
| | Blkrk Strat Inc Oppr I | Mutual Fund | ** | 145 |
| | BlkRk Tctcl Oppr Inst | Mutual Fund | ** | 51,064 |
| | Blkrk Ttl Rtn K | Mutual Fund | ** | 112,556 |
| | Col Sel Lgcap Gr Inst2 | Mutual Fund | ** | 1,696 |
| | De Ivy Gbl Bd I | Mutual Fund | ** | 5,253 |
| | De Ivy Hi Inc R6 | Mutual Fund | ** | 32,301 |

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
EIN 71-0694879
PLAN NUMBER 333

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS
(HELD AT END OF YEAR)
December 31, 2024

| (a) Party-in Interest | (b) Identity of Issue, Borrower, Lessor or Similar Party | (c) Description of investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|--------------------------|---|--|-------------|----------------------|
| | Dfa Emrg Mkt Cor Eq Inst | Mutual Fund | ** | \$ 15,278 |
| | Dfa Gbl Realest Sec Inst | Mutual Fund | ** | 566 |
| | Dfa Us Lgcap Val Inst | Mutual Fund | ** | 1,975 |
| | Dfa Us Trgt Val Inst | Mutual Fund | ** | 573 |
| | Diamond Hill Mdcap I | Mutual Fund | ** | 159,383 |
| | Dodgecox Intl Stk | Mutual Fund | ** | 342,285 |
| | F&T Beh SmCap Eq R6 | Mutual Fund | ** | 21,357 |
| | Fed Hrms Clvr Sm Val Inst | Mutual Fund | ** | 42 |
| | Fed Hrms Gov Oblgtns Prmr | Mutual Fund | ** | 79,512 |
| | Fed Hrms Inst Hyldbnd Inst | Mutual Fund | ** | 186,943 |
| | Fed Hrms Ttl Rtn Bd Inst | Mutual Fund | ** | 106 |
| | Fid 500 Indx | Mutual Fund | ** | 622,986 |
| | Fid Intl Indx | Mutual Fund | ** | 331,756 |
| | Fid Us Bd Indx | Mutual Fund | ** | 320,884 |
| | Fidadv New Mkt Inc I | Mutual Fund | ** | 32,106 |
| | Gdmnscs Gqgptnrintloppr R6 | Mutual Fund | ** | 337,497 |
| | Hartford Divd Gr R6 | Mutual Fund | ** | 95,672 |
| | Invsco Devl Mkt Y | Mutual Fund | ** | 13,532 |
| | Invsco GoldSpecMnrIs Y | Mutual Fund | ** | 1,276 |
| | Invsco Intl Bd Y | Mutual Fund | ** | 62 |
| | Jpm Eq Inc I | Mutual Fund | ** | 57 |
| | Jpm Eq Inc R5 | Mutual Fund | ** | 271,193 |
| | Jpm Gr Advtgr R6 | Mutual Fund | ** | 213,146 |
| | Jpm Lgcap Gr R6 | Mutual Fund | ** | 283,579 |
| | Jpm Smcap Gr R6 | Mutual Fund | ** | 19,668 |
| | Jpm Smartret 2020 R5 | Mutual Fund | ** | 16,938 |

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
EIN 71-0694879
PLAN NUMBER 333
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS
(HELD AT END OF YEAR)
December 31, 2024

| (a) Party-in Interest | (b) Identity of Issue, Borrower, Lessor or Similar Party | (c) Description of investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|-----------------------------|--|---|-------------|-------------------------|
| | Jpm Smartret 2040 R5 | Mutual Fund | ** | \$ 1,372 |
| | Jpm US Eq R5 | Mutual Fund | ** | 399,214 |
| | Legal & Gen Comm Strat Fund | Mutual Fund | ** | 134,944 |
| | Leggm Bw Glbl Oppr Bd Is | Mutual Fund | ** | 37,077 |
| | Leggm Wstras Corplsbd I | Mutual Fund | ** | 38 |
| | Loomis Gr Y | Mutual Fund | ** | 104,252 |
| | Lrdabt Shrt Dur Inc I | Mutual Fund | ** | 23,388 |
| | Mfs MidCap Gr R6 | Mutual Fund | ** | 160,879 |
| | Mfs Rsrch R4 | Mutual Fund | ** | 96 |
| | Mfs Val R4 | Mutual Fund | ** | 86 |
| | Msif Glbl Oppr I | Mutual Fund | ** | 38,422 |
| | Msif Inst Gr I | Mutual Fund | ** | 137,551 |
| | Mnsty Epch Intl Choice I | Mutual Fund | ** | 62 |
| * | Nw Dest 2025 R6 | Mutual Fund | ** | 243,769 |
| * | Nw Dest 2030 R6 | Mutual Fund | ** | 402,302 |
| * | Nw Dest 2035 R6 | Mutual Fund | ** | 336,403 |
| * | Nw Dest 2040 R6 | Mutual Fund | ** | 420,345 |
| * | Nw Dest 2045 R6 | Mutual Fund | ** | 405,080 |
| * | Nw Dest 2050 R6 | Mutual Fund | ** | 287,480 |
| * | Nw Dest 2055 R6 | Mutual Fund | ** | 240,131 |
| * | Nw Dest 2060 R6 | Mutual Fund | ** | 251,767 |
| * | Nw Dest 2065 R6 | Mutual Fund | ** | 32,677 |
| * | Nw Dest Rtrmt R6 | Mutual Fund | ** | 188,640 |
| * | Nw Inv Dest Aggr R6 | Mutual Fund | ** | 127,493 |
| * | Nw Inv Dest Cnsv R6 | Mutual Fund | ** | 54,526 |
| * | Nw Inv Dest Mod Aggr R6 | Mutual Fund | ** | 97,337 |

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST

EIN 71-0694879

PLAN NUMBER 333

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS
(HELD AT END OF YEAR)

December 31, 2024

| (a) Party-in Interest | (b) Identity of Issue, Borrower, Lessor or Similar Party | (c) Description of investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|-----------------------------|--|---|-------------|-------------------------|
| * | Nw Inv Dest Mod Cnstrv R6 | Mutual Fund | ** | \$ 85,968 |
| * | Nw Inv Dest Mod R6 | Mutual Fund | ** | 195,541 |
| * | Nw Loomis Allcap Gr R6 | Mutual Fund | ** | 316,392 |
| | Pgim Hi Yld Z | Mutual Fund | ** | 67 |
| | Pgim Ttl Rtn Bd R6 | Mutual Fund | ** | 272,071 |
| | Pgim Ttl Rtn Bd Z | Mutual Fund | ** | 156 |
| | Pimco EmrgMktLclCrnBd Inst | Mutual Fund | ** | 103 |
| | Pimco Lt Us Gov Inst | Mutual Fund | ** | 34,859 |
| | Pimco Real Rtn Inst | Mutual Fund | ** | 144,578 |
| | Pimcocomdyrealtrnstratinst | Mutual Fund | ** | 8,022 |
| | Primecap Odysy Aggr Gr | Mutual Fund | ** | 67,726 |
| | Prncpl Glbl Realest Inst | Mutual Fund | ** | 163,619 |
| | Prncpl Mdcap Inst | Mutual Fund | ** | 342,182 |
| | Prudntl Glbl Realest Z | Mutual Fund | ** | 73 |
| | Pinm Inc Y | Mutual Fund | ** | 119,599 |
| | Trowepr New Hrizns | Mutual Fund | ** | 114,230 |
| | Tchstn Sandscapemrgmktgr Y | Mutual Fund | ** | 43,087 |
| | Thmpsn Bd | Mutual Fund | ** | 19,676 |
| | Vic Sys Sm Co Oppr I | Mutual Fund | ** | 66,525 |
| | Victory Ultra Short-Term Bond Fund R6 | Mutual Fund | ** | 1,032 |
| | Virtus Conv Inst | Mutual Fund | ** | 3,138 |
| | Virtus KAR SmCap Cor R6 | Mutual Fund | ** | 69,934 |
| | Vngrd Comdty Strat Adml | Mutual Fund | ** | 19,469 |
| | Vngrd Explr Adml | Mutual Fund | ** | 87,723 |
| | Vngrd Explr Inv | Mutual Fund | ** | 42 |
| | Vngrd Intl Gr Adml | Mutual Fund | ** | 205,704 |

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
EIN 71-0694879
PLAN NUMBER 333

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS
(HELD AT END OF YEAR)
December 31, 2024

| (a) Party-in Interest | (b) Identity of Issue, Borrower, Lessor or Similar Party | (c) Description of investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value | (d) Cost | (e) Current Value |
|--------------------------|---|--|-------------|----------------------|
| | Vngrd Lt Invmt Grd Adml | Mutual Fund | ** | \$ 32,065 |
| | Vngrd St Invmt Grd Adml | Mutual Fund | ** | 6,001 |
| | Vngrd Ttl Stmkt Indx Fd As | Mutual Fund | ** | 166 |
| | Abrdn Emrg Mktexchina Inst | Mutual Fund | ** | 65 |
| | Total Assets Held | | | <u>\$ 12,291,247</u> |

*

Denotes party-in-interest

**

Cost information is not required for participant-directed investments and, therefore, is not included

CENTRAL ARKANSAS NURSING CENTERS, INC.
401(k) PLAN AND TRUST
EIN 71-0694879
PLAN NUMBER 333

SCHEDULE H, LINE 4a - SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS
December 31, 2024

| Participant Contributions Transferred Late to Plan | Total that is Fully Corrected Under VFCP | Total that is Fully Corrected Outside of VFCP | Total Waiting to be Fully Corrected |
|---|---|--|--|
| \$53,213 | \$0 | \$0 | \$60,039 |