

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☒ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL
1b	Three-digit plan number (PN) ▶ 001
1c	Effective date of plan 01/01/1963
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) OLEAN GENERAL HOSPITAL 515 MAIN STREET OLEAN, NY 14760-1513
2b	Employer Identification Number (EIN) 16-0743102
2c	Plan Sponsor's telephone number 716-375-6104
2d	Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	04/02/2026	LUCIAN TRUDEAU
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ 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	5 826
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) 296 6a(2) 300 6b 110 6c 390 6d 800 6e 9 6f 809 6g(1) 6g(2) 6h 16
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:

1A

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

a Pension Schedules

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

b General Schedules

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☐ **A** (Insurance Information) – Number Attached _____
- (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 _____

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
▶ Round off amounts to nearest dollar.	
▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.	
A Name of plan PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF OLEAN GENERAL HOSPITAL	D Employer Identification Number (EIN) 16-0743102
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500

Part I	Basic Information			
1	Enter the valuation date: Month 01 Day 01 Year 2024			
2	Assets:			
a	Market value	2a	19485668	
b	Actuarial value	2b	20268359	
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a	For retired participants and beneficiaries receiving payment	118	5667668	5667668
b	For terminated vested participants	412	10158246	10158246
c	For active participants	314	9248102	9355244
d	Total	844	25074016	25181158
4	If the plan is in at-risk status, check the box and complete lines (a) and (b). ☐			
a	Funding target disregarding prescribed at-risk assumptions	4a		
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5	Effective interest rate	5	5.25 %	
6	Target normal cost			
a	Present value of current plan year accruals	6a	731080	
b	Expected plan-related expenses	6b	697335	
c	Target normal cost	6c	1428415	

Statement by Enrolled Actuary
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	Signature of actuary GREGORY M. STUMP Type or print name of actuary BOOMERSHINE CONSULTING GROUP L.L.C. Firm name 3300 N. RIDGE RD. SUITE 300 ELLCOTT CITY, MD 21043 Address of the firm	09/30/2025 Date 23-06998 Most recent enrollment number 410-418-5525 Telephone number (including area code)
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Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	784919
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)		784919
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>10.94</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		29515
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.34</u> %		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		3229
c Total available at beginning of current plan year to add to prefunding balance		32744
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	80.49 %
15 Adjusted funding target attainment percentage	15	80.49 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	81.47 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/23/2024	429075		01/23/2025	414300	
04/23/2024	4925		01/23/2025	19700	
07/11/2024	424150		03/31/2025	675000	
07/11/2024	9850				
10/21/2024	419225				
10/21/2024	14775				
Totals ▶			18(b)	2411000	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	
b Contributions made to avoid restrictions adjusted to valuation date	19b	402841
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	1907000

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☒ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.75 %	2nd segment: 4.96 %	3rd segment: 5.59 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 0
22 Weighted average retirement age				22 64
23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
26 Demographic and benefit information	
a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	☒ Yes ☐ No
b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ...	☐ Yes ☒ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29).....	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6c)	31a	1428415	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	4912799	478585	
b Waiver amortization installment		0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....	34	1907000	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0
36 Additional cash requirement (line 34 minus line 35)	36	1907000	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	1907000	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	0	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)

41 If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies. ☐ 2019 ☐ 2020 ☐ 2021

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.	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 PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 OLEAN GENERAL HOSPITAL	D Employer Identification Number (EIN) 16-0743102	

Part I	Service Provider Information (see instructions)
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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	
DRAKE CAPITAL ADVISORS L.L.C.	
06-1609791	

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
EVANSTON CAPITAL MANAGEMENT, LLC	1560 SHERMAN AVE SUITE 960 EVANSTON, IL 60201

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
FIRST PACIFIC ADVISORS, LP	
20-1362771	

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
HARTFORD FUNDS MANAGEMENT COMPANY	
46-1470670	

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

THE VANGUARD GROUP, INC.

23-1945930

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

BLACKROCK ADVISORS, LLC

23-2784752

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

BLACKROCK FUND ADVISORS

23-2784752

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

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

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

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

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

BOOMERSHINE CONSULTING GROUP, LLC

20-8714603

(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?
11	N/A	216372	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PRIME, BUCHHOLZ & ASSOCIATES

02-0426421

(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	N/A	32813	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

COMMUNITY BANK

15-0436580

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21	N/A	22228	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

STATE STREET GLOBAL ADVISORS

04-1867445

(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?
51 18 19	N/A	4213	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

PARNASSUS INVESTMENTS

1 MARKET STREET
SUITE 1600
SAN FRANCISCO, CA 94105

(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?
52	N/A	0	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

T. ROWE PRICE ASSOCIATES, INC.

100 EAST PRATT STREET
BALTIMORE, MD 21202

(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?
52	N/A	0	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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)

HARBOR CAPITAL ADVISOR, INC.

34-1953397

(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?
52	N/A	0	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

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 D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration		DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.		OMB No. 1210-0110 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 PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL				B Three-digit plan number (PN) ▶ 001	
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 OLEAN GENERAL HOSPITAL				D Employer Identification Number (EIN) 16-0743102	
Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)					
a Name of MTIA, CCT, PSA, or 103-12 IE: SSGA REAL ASSET NL FUND (ZVBQ)					
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS					
c EIN-PN 90-0337987-291		d Entity code C		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1968292	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
a Name of MTIA, CCT, PSA, or 103-12 IE:					
b Name of sponsor of entity listed in (a):					
c EIN-PN		d Entity code		e Dollar value of interest in MTIA, CCT, PSA,	

a Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN

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

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

A Name of plan PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL	B Three-digit plan number (PN) 001
C Plan sponsor's name as shown on line 2a of Form 5500 OLEAN GENERAL HOSPITAL	D Employer Identification Number (EIN) 16-0743102

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.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions.....	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	394273	442622
(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)	8126	10707
(5) Partnership/joint venture interests	1c(5)	3453565	3525139
(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)	1838531	1968292
(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)	13434951	14015639
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	19129446	19962399
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	19129446	19962399

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)	1662000	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B), (C), and line 2a(2)	2a(3)		1662000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	18643	
(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)		18643
(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)	537375	
(D) Total dividends. Add lines 2b(2)(A) , (B), and (C)	2b(2)(D)		537375
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	517147	
(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)	775644	
(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)		169257
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		3680066

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	2201030	
(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)		2201030
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	37026	
(6) Bank or trust company trustee/custodial fees	2i(6)	22228	
(7) Actuarial fees	2i(7)	216372	
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	370457	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		646083
j Total expenses. Add all expense amounts in column (b) and enter total	2j		2847113

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		832953
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: **LUMSDEN AND MCCORMICK**

(2) EIN: **16-0765486**

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.)		☒	
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.)		☒	
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.)		☒	
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.)		☒	
e Was this plan covered by a fidelity bond?	☒		1500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		☒	
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?		☒	
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?		☒	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	☒		
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.)	☒		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☒	
l Has the plan failed to provide any benefit when due under the plan?		☒	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☒ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 571594.

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation		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 PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL				B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 OLEAN GENERAL HOSPITAL				D Employer Identification Number (EIN) 16-0743102	
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	
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): 15-0436580					
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	29
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					
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.				Schedule R (Form 5500) 2024 v. 240311	

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: ☐ last contributing employer ☐ alternative ☐ reasonable approximation (see instructions for required attachment).....

14a

b The plan year immediately preceding the current plan year. ☐ 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. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....

14c

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

a The corresponding number for the plan year immediately preceding the current plan year.....

15a

b The corresponding number for the second preceding plan year.....

15b

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

a Enter the number of employers who withdrew during the preceding plan year.....

16a

b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....

16b

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

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

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

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

a Enter the percentage of plan assets held as:

Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%

High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:

☐ 0-5 years ☐ 5-10 years ☐ 10-15 years ☐ 15 years or more

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

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

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

☐ Yes.

☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

☐ No. Other. Provide explanation.....

Part VII IRS Compliance Questions

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

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

☐ Design-based safe harbor method

☐ "Prior year" ADP test

☐ "Current year" ADP test

☐ N/A

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

**PENSION PROGRAM FOR EMPLOYEES OF
OLEAN GENERAL HOSPITAL**

**FINANCIAL STATEMENTS
WITH ADDITIONAL INFORMATION**

December 31, 2024

INDEPENDENT AUDITORS' REPORT

The Plan Administrator
Pension Program for Employees of Olean General Hospital

Opinion

We have audited the financial statements of Pension Program For Employees of Olean General Hospital (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits as of December 31, 2024 and 2023 and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, information regarding the Plan's net assets available for benefits as of December 31, 2024 and 2023, and the changes in its net assets available for benefits for the years then ended in accordance with accounting principles generally accepted in the United States of America (GAAP).

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 Auditors' 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 the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Plan management is responsible for the preparation and fair presentation of the financial statements in accordance with GAAP, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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 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.

Auditors' Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

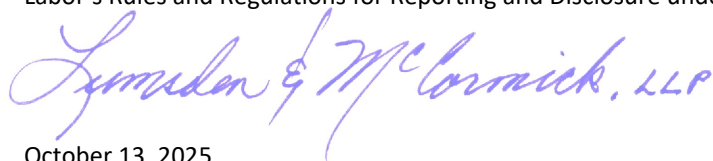
We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules on pages 8 and 9 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

A handwritten signature in blue ink that reads "Lyndon & McCormick, LLP". The signature is written in a cursive, flowing style.

October 13, 2025

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

Statements of Net Assets Available for Benefits

December 31,	2024	2023
Investments:		
Mutual funds	\$ 14,015,639	\$ 13,434,951
Money market and similar funds	442,622	394,273
Limited partnership investment funds	3,525,139	3,453,565
Common collective trust	1,968,292	1,838,531
Common stock	10,707	8,126
	<u>19,962,399</u>	<u>19,129,446</u>
Receivables - employer contributions	<u>1,109,000</u>	<u>360,000</u>
Net assets available for benefits	<u>\$ 21,071,399</u>	<u>\$ 19,489,446</u>

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

Statements of Changes in Net Assets Available for Benefits

For the years ended December 31,	2024	2023
Additions to net assets:		
Investment income:		
Net appreciation in fair value of investments	\$ 1,462,048	\$ 1,562,619
Interest and dividends	556,018	457,761
	2,018,066	2,020,380
Less investment expenses	37,026	37,020
	1,981,040	1,983,360
Employer contributions	2,411,000	1,020,000
Total additions	4,392,040	3,003,360
Deductions from net assets:		
Benefits paid to participants	2,201,030	2,646,728
Administrative expenses	609,057	660,314
Total deductions	2,810,087	3,307,042
Change in net assets available for benefits	1,581,953	(303,682)
Balance - beginning	19,489,446	19,793,128
Balance - ending	\$ 21,071,399	\$ 19,489,446

See accompanying notes.

Notes to Financial Statements

1. Plan Description:

Pension Program for Employees of Olean General Hospital (the Plan) is a noncontributory defined benefit pension plan covering substantially all employees of Olean General Hospital (the Hospital). The Plan provides retirement and disability benefits that are based on salary and length of service. Employees are generally eligible to participate in the Plan at age 20½ after one year of service. Refer to the Plan document maintained by the Hospital for a further description of Plan provisions.

A participant becomes eligible for normal retirement benefits at age 65 or a reduced benefit at age 55 with 10 years of service. Disability benefits are available to participants with 10 years of service.

Effective April 1, 2011, all non-union participant benefits as of that date were frozen. An enhanced defined contribution Section 403(b) savings incentive plan replaced the pension benefits for non-union employees.

2. Significant Accounting Policies:

Basis of Accounting:

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

These financial statements differ from the Plan's Form 5500 in that receivables are not recognized in the Form 5500.

Investment Valuation and Income Recognition:

The Plan invests in two limited partnership investment funds and a common collective trust for the purpose of investing in real estate and international markets. Investments in these items are valued based on the Plan's proportionate share of net assets at the valuation date. The Plan's ownership interests are valued in good faith at net asset value by the Plan Administrator based on the fair values of the investments' interests in the underlying assets and may consider other factors such as ownership percentage, ownership rights, and distribution provisions. Limited partnership investment fund interests may only be redeemed annually with notice of 65 - 90 days.

The Plan's other investments are valued based on quoted prices in active markets.

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. Unrealized appreciation or depreciation on investments is charged or credited to the net assets of the Plan.

Actuarial Method and Funding Policy:

The actuarial cost method used to determine Plan funding requirements is the Unit Credit Method. Under this method, the projected monthly benefit is estimated (reflecting assumed salary increases if applicable) and the projected accrued benefit is determined as the portion of the projected benefit attributable to years of service completed prior to the current plan year. The Actuarial Accrued Liability is equal to the Actuarial Present Value of all projected accrued benefits as of the Valuation Date.

The Normal Cost is the Actuarial Present Value, as of the Valuation Date, of the expected increases in projected accrued benefit attributable to service expected to be completed during the Plan Year. Under the Unit Credit Actuarial Cost Method, experience gains or losses and changes in the Actuarial Accrued Liability resulting from changes in the actuarial assumptions or from changes in the plan provisions are reflected as decreases or increases in the Unfunded Actuarial Accrued Liability, to be funded through amortization payments.

The Hospital has agreed to contribute such amounts as annually determined by actuarial calculations necessary to prevent a funding deficiency as defined by the Employee Retirement Income Security Act of 1974 (ERISA).

Use of Estimates:

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Subsequent Events:

The Plan has evaluated events and transactions for potential recognition or disclosure in the financial statements through October 13, 2025, the date the financial statements were available to be issued.

3. Administrative Expenses:

Various Plan administrative expenses are paid by the Hospital. Trustee fees and professional fees totaling \$238,600 and \$191,518 were paid by the Plan for the years ended December 31, 2024 and 2023. The Plan paid Pension Benefit Guaranty Corporation (PBGC) premiums totaling \$370,457 and \$468,796 for the years ended December 31, 2024 and 2023.

4. Tax Status:

The Internal Revenue Service has issued a favorable determination letter regarding the tax-exempt status of the Plan. Accordingly, no provision has been made for income taxes.

5. Termination of the Plan:

The Hospital has the right to terminate the Plan and discontinue contributions. In the event of a termination and after final expenses, each participant's accrued benefit shall be fully vested to the extent funded. Certain benefits under the Plan are insured by the PBGC if the Plan terminates. Generally, the PBGC guarantees most vested normal retirement age benefits, early retirement benefits and certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under the Plan and the amount of benefit protection is subject to certain limitations. Whether all participants receive their benefits should the Plan terminate at some future time will depend on the sufficiency, at that time, of the Plan's net assets to provide those benefits and may also depend on the level of benefits guaranteed by the PBGC. Any assets remaining after the satisfaction of liabilities shall be distributed to the Hospital.

6. Actuarial Present Value of Accumulated Plan Benefits and Actuarial Assumptions:

The actuarial present value of accumulated Plan benefits is determined by an actuary and is that amount that results from applying actuarial assumptions to adjust the accumulated plan benefits to reflect the time value of money between the valuation date and the expected date of payment. The significant actuarial assumptions used in the valuation as of December 31, 2023 are (a) life expectancy of participants (2024 IRS Annuitant and Non-Annuitant tables), (b) retirement age assumptions (a normal retirement at age 65), (c) salary increases (2.00% per year plus step increase ranging from 1.50% – 7.30% based on years of service for participants covered by a collective bargaining agreement who continue to accrue benefits in the Plan), and (d) investment return of 6.75%.

For the years ended December 31, 2024 and 2023, the actuarial present value of accumulated plan benefits is presented as of the beginning of the plan year. The actuarial present value of accumulated plan benefits at December 31, 2023 is:

Vested:	
Participants currently receiving payments	\$ 5,216,212
Other participants	16,946,059
	<u>22,162,271</u>
Non-vested	80,583
Total actuarial present value	<u>\$ 22,242,854</u>

The change in the actuarial present value of all accrued benefits during the year ended December 31, 2023 is shown below:

Value as of December 31, 2022	\$ 23,073,661
Benefit payments	(2,646,728)
Assumption changes	(379,190)
Other (includes benefits accumulated)	2,195,111
Value as of December 31, 2023	<u>\$ 22,242,854</u>

Assumption changes that impacted the value of accumulated plan benefits above include updated IRS mortality tables, changes in lump sum conversion interest rates from 2022, adjusted funding segment rates (4.75%, 5.00%, and 5.74%) to 2023 adjusted funding segment rates (4.75%, 4.96%, and 5.59%), change in pre/post-retirement mortality, and a change in the discount rate (5.34% in 2023; 5.51% in 2022).

7. Risks and Uncertainties:

The Plan invests in various investment securities. Investment securities are exposed to 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 the amounts reported in the statement of net assets available for benefits.

Plan contributions are made, and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

8. Related-Party and Party-in-Interest Transactions:

Community Bank, N.A. is an investment custodian. Community Bank, N.A. proprietary money market and similar funds totaled \$442,622 and \$394,273 at December 31, 2024 and 2023.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102

Plan Number 001 - Supplementary Information

Schedule H, Line 4i

Schedule of Assets Held for Investment Purposes at December 31, 2024

(a)	(b)	(c)	(d)	(e)
	Identity of Issue	Shares/ Par Value	Cost/ Book Value	Current Value
Mutual funds:				
	Vanguard Total Stock Market Index Fund Admiral Shares	29,616	\$ 2,568,721	\$ 4,176,746
	T. Rowe Price Total Return Fund Total Return I	234,429	2,414,550	1,941,069
	Harbor Diversified International All Cap Fund Institutional Class	136,292	1,384,188	1,642,323
	Vanguard Intermediate - Term Treasury Fund Admiral Shares	183,932	2,106,756	1,789,655
	Vanguard Total International Stock Index Fund Admiral	53,937	1,499,188	1,709,254
	Parnassus Core Equity Fund - Institutional Shares	22,846	1,101,293	1,365,069
	Hartford World Bond Fund Class Y	66,796	707,394	671,304
	FPA Crescent Fund Supra Institutional Class	6,713	257,941	270,180
	BlackRock Event Driven Equity Fund	22,014	219,798	220,144
	BlackRock Strategic Income Opportunities Portfolio Investor A Shares	24,276	246,804	229,895
	Total mutual funds			<u>14,015,639</u>
Money market and similar funds:				
*	CBNA Daily Trust Sweep		442,622	442,622
Limited Partnership Investment Funds:				
	Weatherlow Offshore Fund II LTD	1,009	1,168,720	2,183,583
	Drake Capital Offshore Partners, L.P.	750,000	750,000	1,341,556
	Total limited partnership investment funds			<u>3,525,139</u>
Common Collective Trust:				
	SSGA Real Asset NL Fund	109,174	1,322,308	1,968,292
Common stock:				
	MetLife		137	<u>10,707</u>
				<u>\$ 19,962,399</u>

* These investments are with parties-in-interest.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102

Plan Number 001 - Supplementary Information

Schedule H, Line 4j

Schedule of Reportable Transactions for the year ended December 31, 2024

(a) Identity of Party Involved	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value on Transaction Date	(i) Net Gain or (Loss)
---	--------------------------------	--------------------------	-------------------------	-------------------------	--	------------------------------

Series of transactions in excess of 5% of Plan Assets:

Community Bank, N.A.	Money Market	\$ 3,385,462	\$ -	\$ 3,385,462	\$ 3,385,462	\$ -
Community Bank, N.A.	Money Market	\$ -	\$ 3,337,113	\$ 3,337,113	\$ 3,337,113	\$ -



April 3, 2026

Mr. David S. Boomershine
Senior Actuary and President
Boomershine Consulting Group, L.L.C.
3300 North Ridge Rd., Suite 300
Ellicott City, MD 21043

Re: **EFAST2 E-Signature Option**

Dear Dave,

This letter is to inform you that I am authorizing Boomershine Consulting Group, LLC to electronically submit the **amended 2024** Form 5500 and attachments for the **Pension Program for Employees of Olean General Hospital**. I understand that in giving this authorization my signature will be posted on the internet and available on the EFAST2 website.

Sincerely,

A handwritten signature in black ink, appearing to read "Lucian Trudeau".

Lucian Trudeau
Assistant Director

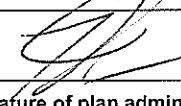
Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
--	---	---

Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report ☐ the final return/report ☒ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.	☐

Part II	Basic Plan Information—enter all requested information	
1a Name of plan Pension Program for Employees of Olean General Hospital	1b Three-digit plan number (PN) ▶	001
	1c Effective date of plan	01/01/1963
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Olean General Hospital 515 Main Street Olean NY 14760-1513	2b Employer Identification Number (EIN) 16-0743102	2c Plan Sponsor's telephone number (716) 375-6104
	2d Business code (see instructions) 622000	

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

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

SIGN HERE		4/3/2026	Lucian Trudeau
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address ☒ 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	5 826
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) 296 6a(2) 300 6b 110 6c 390 6d 800 6e 9 6f 809 6g(1) 6g(2) 6h 16
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: 1A 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) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ 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 _____ (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 _____

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2024 Schedule SB, Line 26a

Schedule of Active Participant Data																			
YEARS OF CREDITED SERVICE																			
Attained Age	Under 1		1 to 4		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34		35 to 39		40 & up
	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.	Average Comp.	No.
Under 25	6		14		0		0		0		0		0		0		0		0
25 to 29	3		15		3		0		0		0		0		0		0		0
30 to 34	2		19		3		1		0		0		0		0		0		0
35 to 39	7		23		8		5		0		0		0		0		0		0
40 to 44	4		16		7		6		2		0		0		0		0		0
45 to 49	2		7		7		7		3		2		0		0		0		0
50 to 54	0		5		7		5		5		5		0		2		0		0
55 to 59	1		10		9		8		7		14		3		5		1		0
60 to 64	0		9		5		6		6		12		2		2		1		0
65 to 69	0		0		2		1		2		2		1		1		0		0
70 & up	0		1		0		0		0		0		1		1		0		0

Plan Name: Pension Program for Employees of Olean General Hospital

EIN: 16-0743102

Plan No.: 001

2024 Schedule SB, Line 22

SCHEDULE SB, LINE 22 - DESCRIPTION OF WEIGHTED AVERAGE RETIREMENT AGE

Age (Input)	Rate (Input)	Retiring (Calc)	Remaining (Calc)	Weighted (Calc)	
55	1.50%	0.015000	0.985000	0.825000	
56	1.50%	0.014775	0.970225	0.827400	
57	1.50%	0.014553	0.955672	0.829542	
58	1.50%	0.014335	0.941337	0.831434	
59	5.00%	0.047067	0.894270	2.776943	
60	5.00%	0.044713	0.849556	2.682809	
61	5.00%	0.042478	0.807078	2.591147	
62	20.00%	0.161416	0.645663	10.007772	
63	7.50%	0.048425	0.597238	3.050756	
64	7.50%	0.044793	0.552445	2.866743	
65	55.00%	0.303845	0.248600	19.749915	
66	50.00%	0.124300	0.124300	8.203811	
67	15.00%	0.018645	0.105655	1.249217	
68	15.00%	0.015848	0.089807	1.077682	
69	40.00%	0.035923	0.053884	2.478670	
70	100.00%	0.053884	0.000000	3.771889	Sum = 63.820730 = Weighted Average Retirement Age

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2024 Schedule SB, Part V

SCHEDULE SB, PART V - SUMMARY OF PLAN PROVISIONS

EFFECTIVE DATE: The original effective date of the Plan is January 1, 1963.

PLAN FREEZE: Effective March 31, 2011, participation, benefit service and accrued benefits are frozen under the Plan, except for those individuals covered by the collective bargaining agreement (i.e. RNs).

VALUATION DATE: January 1.

PLAN YEAR: January 1 through December 31.

ELIGIBILITY: An Employee is eligible to participate in the Plan on the January 1 or July 1 coincident with or next following completion of one Year of Eligibility Service in which the Employee has at least 1,000 hours of service and attainment of age 20-1/2. No individuals who meet the above requirements can become a participant after March 31, 2011 unless they are covered by the collective bargaining agreement.

BENEFIT SERVICE:

One year of Benefit Service is credited for each Plan Year in which the Employee has at least 1,000 Hours of Service. Years of service begin on the later of January 1, 1989 or the date of participation. If the Employee was a participant before January 1, 1989, service prior to January 1, 1989 will be taken into account, except that no credit will be received for any period during which required employee contributions were not made. Partial Service is credited for the first and last Plan Year of employment if the Employee has less than 1,000 Hours. Partial credit is equal to Hours of Service divided by 1,000.

Benefit service is not credited after March 31, 2011 except for those union participants who are not included in the Plan freeze.

VESTING SERVICE: A year of Vesting Service is given for each Plan Year in which the Employee has at least 1,000 hours. No Vesting Service is given prior to age 18.

COMPENSATION: Compensation is an Employee's W-2 earnings plus any amounts deferred under a salary reduction agreement under Internal Revenue Code Sections 401(k), 125, 402(e)(3), 402(h)(1)(B), or 403(b).

Compensation is averaged during the five highest consecutive years of employment prior to the determination date. If the participant has less than five consecutive years, Compensation is averaged over the period of employment.

Compensation is not credited after March 31, 2011 except for those union participants who are not included in the Plan freeze.

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2024 Schedule SB, Part V

SCHEDULE SB, PART V - SUMMARY OF PLAN PROVISIONS
(Continued)

RETIREMENT DATES:

- (a) Normal Retirement: A participant's Normal Retirement Date is the first day of the month coincident with or next following the later of age 65 and the fifth anniversary of Plan participation.
- (b) Early Retirement: A participant may elect early retirement after attaining age 55 and completing 10 years of Vesting Service.
- (c) Disability Retirement: A participant will be eligible for disability retirement after becoming totally and permanently disabled, as defined under the Social Security Act, and completing at least 10 years of Vesting Service.
- (d) Deferred Retirement: A participant may continue to work beyond Normal Retirement Date.

AMOUNT OF RETIREMENT BENEFIT:

- (a) Normal Retirement: A participant's normal retirement benefit is equal to the greater of:
 - (i) 0.75% of final average compensation multiplied by years of Benefit Service with a maximum of 50 years.
 - (ii) 0.70% of final average compensation not in excess of Covered Compensation plus 1.15% of final average compensation in excess of Covered Compensation, multiplied by years of Benefit Service with a maximum of 50 years.

Accrued benefits are frozen as of March 31, 2011 except for those union participants who are not included in the Plan freeze.

- (b) Early Retirement: The early retirement benefit is calculated in the same way as a normal retirement benefit. If payments begin prior to Normal Retirement Date, the amount of benefit will be reduced. The reduction is equal to the greater of 0.5% for each month payments precede Normal Retirement Date or the actuarially equivalent benefit, with a maximum early retirement factor from Table 1 in the Plan document.
- (c) Disability Retirement: The disability retirement benefit is calculated in the same way as a normal retirement benefit. If payments begin prior to Normal Retirement Date, the amount of benefit will be reduced. The reduction is equal to the greater of 0.5% for each month payments precede Normal Retirement Date or the actuarially equivalent benefit.
- (d) Deferred Retirement: The retirement benefit payable when a participant actually retires will be based on Benefit Service and final average compensation at that time. The benefit is subject to the suspension of benefit regulations.

OPTIONAL FORMS OF BENEFIT PAYMENT:

- (a) Life Annuity: Monthly payments will be made to the retired participant during his lifetime. After his death, no further payments are made.
- (b) Joint and Contingent Annuitant: Reduced monthly payments will be made to the retired participant during his lifetime. After his death, payments of 100%, 75%, 66-2/3% or 50% of the participant's payment will be continued to the designated beneficiary for the beneficiary's lifetime.

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2024 Schedule SB, Part V

SCHEDULE SB, PART V - SUMMARY OF PLAN PROVISIONS
(Continued)

- (c) Social Security Adjustment: Increased monthly payments will be made to the retired participant during his lifetime and prior to the date that Social Security payments begin. After Social Security payments start, while the participant is still living, monthly payments from the Plan will be reduced so that the total monthly payments before and after Social Security begins will be approximately equal.
- (d) Lump Sum: For retired participants, in lieu of receiving monthly payments, a single payment of the present value of the benefit may be made. This lump sum option is not available to participants who entered the Plan on or after February 1, 2010. However, a lump sum valued at \$7,000 or less may be made to any terminated participant.

PRE-RETIREMENT DEATH BENEFITS: If a married participant who is vested dies prior to his benefit commencement date, his surviving spouse will be entitled to a monthly death benefit. If the participant dies prior to becoming eligible for early retirement, the death benefit is equal to the amount the spouse would have received if the participant had terminated employment on his date of death, survived to early retirement, selected the Joint and 50% option, and died the next day. If the participant dies after become eligible for early retirement, the death benefit is equal to the amount the spouse would have received if the participant had retired the day before his death and selected the Joint and 50% option. The Plan does not provide a pre-retirement death benefit for vested non-married participants.

If no death benefit is payable above, the beneficiary will receive a return of accumulated employee contributions, if any.

VESTING: A participant is 100% vested in his accrued benefit after the earlier of: (1) completing five years of Vesting Service and (2) attaining normal retirement age.

CONTRIBUTIONS: The Employer pays the entire cost of the Plan. Prior to January 1, 1989 employee contributions were required for Plan participation.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102

Plan Number 001 - Supplementary Information

Schedule H, Line 4i

Schedule of Assets Held for Investment Purposes at December 31, 2024

(a)	(b)	(c)	(d)	(e)
	Identity of Issue	Shares/ Par Value	Cost/ Book Value	Current Value
Mutual funds:				
	Vanguard Total Stock Market Index Fund Admiral Shares	29,616	\$ 2,568,721	\$ 4,176,746
	T. Rowe Price Total Return Fund Total Return I	234,429	2,414,550	1,941,069
	Harbor Diversified International All Cap Fund Institutional Class	136,292	1,384,188	1,642,323
	Vanguard Intermediate - Term Treasury Fund Admiral Shares	183,932	2,106,756	1,789,655
	Vanguard Total International Stock Index Fund Admiral	53,937	1,499,188	1,709,254
	Parnassus Core Equity Fund - Institutional Shares	22,846	1,101,293	1,365,069
	Hartford World Bond Fund Class Y	66,796	707,394	671,304
	FPA Crescent Fund Supra Institutional Class	6,713	257,941	270,180
	BlackRock Event Driven Equity Fund	22,014	219,798	220,144
	BlackRock Strategic Income Opportunities Portfolio Investor A Shares	24,276	246,804	229,895
	Total mutual funds			<u>14,015,639</u>
Money market and similar funds:				
*	CBNA Daily Trust Sweep		442,622	442,622
Limited Partnership Investment Funds:				
	Weatherlow Offshore Fund II LTD	1,009	1,168,720	2,183,583
	Drake Capital Offshore Partners, L.P.	750,000	750,000	1,341,556
	Total limited partnership investment funds			<u>3,525,139</u>
Common Collective Trust:				
	SSGA Real Asset NL Fund	109,174	1,322,308	1,968,292
Common stock:				
	MetLife		137	<u>10,707</u>
				<u>\$ 19,962,399</u>

* These investments are with parties-in-interest.

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 8059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

▶ Round off amounts to nearest dollar.

▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan Pension Program for Employees of Olean General Hospital	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Olean General Hospital	D Employer Identification Number (EIN) <u>16-0743102</u>
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	
F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500	

Part I Basic Information			
1 Enter the valuation date: Month <u>1</u> Day <u>1</u> Year <u>2024</u>			
2 Assets:			
a Market value.....	2a	19,485,668	
b Actuarial value.....	2b	20,268,359	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment.....	118	5,667,668	5,667,668
b For terminated vested participants.....	412	10,158,246	10,158,246
c For active participants.....	314	9,248,102	9,355,244
d Total.....	844	25,074,016	25,181,158
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... ☐			
a Funding target disregarding prescribed at-risk assumptions.....	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	4b		
5 Effective interest rate.....	5	5.25 %	
6 Target normal cost.....			
a Present value of current plan year accruals.....	6a	731,080	
b Expected plan-related expenses.....	6b	697,335	
c Target normal cost.....	6c	1,428,415	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	 Signature of actuary <u>GREGORY M. STUMP</u> Type or print name of actuary <u>BOOMERSHINE CONSULTING GROUP L.L.C.</u> Firm name <u>3300 N. RIDGE RD. SUITE 300</u> <u>ELLICOTT CITY</u> <u>MD 21043</u> Address of the firm	<u>9/30/2025</u> Date <u>23-06998</u> Most recent enrollment number <u>(410) 418-5525</u> Telephone number (including area code)
----------------------	--	--

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2024
v. 240311

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102

Plan Number 001 - Supplementary Information

Schedule H, Line 4j

Schedule of Reportable Transactions for the year ended December 31, 2024

(a) Identity of Party Involved	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value on Transaction Date	(i) Net Gain or (Loss)
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Series of transactions in excess of 5% of Plan Assets:

Community Bank, N.A.	Money Market	\$ 3,385,462	\$ -	\$ 3,385,462	\$ 3,385,462	\$ -
Community Bank, N.A.	Money Market	\$ -	\$ 3,337,113	\$ 3,337,113	\$ 3,337,113	\$ -

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2024 Schedule SB, Line 32

SCHEDULE SB, LINE 32 - SCHEDULE OF AMORTIZATION BASES

<u>Valuation Date</u>	<u>Shortfall Base</u>	<u>Remaining Base as of 1/1/2024</u>	<u>Number of Yrs Remaining</u>	<u>Payment</u>
1/1/2022	1,977,240	1,809,051	13	182,720
1/1/2023	2,869,194	2,741,571	14	262,763
1/1/2024	362,177	<u>362,177</u>	15	<u>33,102</u>
<u>Total:</u>		4,912,799		478,585

Plan Name: Pension Program for Employees of Olean General Hospital

EIN: 16-0743102

Plan No.: 001

2024 Schedule SB, Line 19

SCHEDULE SB, LINE 19 - DISCOUNTED EMPLOYER CONTRIBUTIONS

<u>Contribution</u>	<u>Date</u>	<u>Plan Year</u>	<u>Adjustment Interest Rate</u>	<u>Adjustment Period</u>	<u>Adjustment Interest Rate</u>	<u>Adjustment Period</u>	<u>Discounted Contribution</u>
429,075	4/23/2024	2024	5.25%	4/15/2024 to 1/1/2024	10.25%	4/23/24 to 1/1/2024	421,921
4,925	4/23/2024	2024	5.25%	4/23/2024 to 1/1/2024			4,847
424,150	7/11/2024	2024	5.25%	7/11/2024 to 1/1/2024			412,916
9,850	7/11/2024	2024	5.25%	7/11/2024 to 1/1/2024			9,589
419,225	10/21/2024	2024	5.25%	10/15/2024 to 1/1/2024	10.25%	10/21/24 to 1/1/2024	402,037
14,775	10/21/2024	2024	5.25%	10/21/2024 to 1/1/2024			14,180
414,300	1/23/2025	2024	5.25%	1/15/2025 to 1/1/2024	10.25%	1/23/2025 to 1/1/2024	392,027
19,700	1/23/2025	2024	5.25%	1/23/2025 to 1/1/2024			18,659
<u>675,000</u>	3/28/2024	2024	5.25%	3/28/2025 to 1/1/2024			<u>633,665</u>
2,411,000							2,309,841

Plan Name: Pension Program for Employees of Olean General Hospital
 EIN: 16-0743102
 Plan No.: 001
 2024 Schedule SB, Part V

SCHEDULE SB, PART V - STATEMENT OF ACTUARIAL ASSUMPTIONS/METHODS

1. Actuarial Assumptions:

The non-prescribed demographic assumptions used in the valuation are based on an assumption review completed in 2016 and have mostly remained the same as last year. Any differences are noted.

- (a) Interest Rates: 1/1/2024
 ERISA Funding (reflecting Pension Relief through IJJA):
 First Segment 4.75%
 Second Segment 4.96%
 Third Segment 5.59%
 Plan's Effective Interest Rate 5.25%
- (b) Mortality Before and After Retirement:
 ERISA funding: IRS 2024 Annuitant/Non-annuitant tables
- (c) Salary Scale: Increases from Collective Bargaining Agreement
 2.00% per year, plus the following step increases:
- | <u>Service</u> | <u>Increase</u> | <u>Service</u> | <u>Increase</u> |
|----------------|-----------------|----------------|-----------------|
| 1 | 3.50% | 15 | 2.70% |
| 2 | 3.10% | 20 | 7.30% |
| 5 | 6.40% | 25 | 3.80% |
| 7 | 2.90% | 30 | 1.50% |
| 10 | 3.80% | | |
- (d) Lump sum conversion:
 ERISA funding: 2024 funding segment rates, IRS 2024 417(e) mortality
- (e) Social Security Taxable Wage Base Increase: 2.00% per year
- (f) Benefit Payments: 70% of active and terminated vested participants are assumed to elect the lump sum option and 30% are assumed to elect the life annuity option. For individuals who began participating on or after February 1, 2010, 100% are assumed to elect the life annuity option. Future lump sum payments are valued using the funding interest rates and the unisex mortality table from IRC Section 417(e).
- (g) Benefit Commencement for Deferred Vested Participants: at normal retirement date, or immediately if past normal retirement date
- (h) Benefit Commencement for Active Participants: Retirement - based on retirement rates; Death - at participant's earliest retirement date; Withdrawal - at participant's normal retirement date
- (i) Interest credit on Employee Contributions: 5.25% per year (120% Annual AFR Mid-Term January 2024)
- (j) Marriage and Age of Spouse: 75% of employees are assumed to be married. Wives are assumed to be three years younger than their husbands.
- (k) Withdrawal Before Retirement:
- | <u>Age</u> | <u>Males</u> | <u>Females</u> | <u>Age</u> | <u>Males</u> | <u>Females</u> |
|------------|--------------|----------------|------------|--------------|----------------|
| 20-24 | 25.00% | 20.00% | 45-49 | 11.10% | 8.90% |
| 25-29 | 21.30% | 17.00% | 50-54 | 9.40% | 7.50% |
| 30-34 | 18.10% | 14.50% | 55-59 | 8.00% | 6.40% |
| 35-39 | 15.40% | 12.30% | 60-64 | 6.80% | 5.40% |
| 40-44 | 13.10% | 10.40% | 65-69 | 5.80% | 4.60% |

SCHEDULE SB, PART V - STATEMENT OF ACTUARIAL ASSUMPTIONS/METHODS (Continued)

(l) Retirement Rates:

<u>Age</u>	<u>Rate</u>	<u>Age</u>	<u>Rate</u>
55 - 58	1.5%	66	50.0%
59 - 61	5.0%	67 - 68	15.0%
62	20.0%	69	40.0%
63 - 64	7.5%	70+	100.0%
65	55%		

(m) All participants are included in plan costs.

(n) Plan Value of Assets: Beginning January 1, 2009, the Plan Value of Assets is equal to a two-year smoothed average of the fair market value of assets in accordance with IRS Notice 2009-22. The average plan value cannot exceed 110% or be less than 90% of the market value.

(o) Expenses: Plan-related expenses are estimated to be equal to the plan-related expenses for the prior Plan Year.

2. Actuarial Cost Method:

The actuarial cost method used in the funding valuation is the Unit Credit method. The actuarial present value of the benefits accruing during the year is the Target Normal Cost for the participant. The Plan's Target Normal Cost is the sum of each participant's Target Normal Cost. The actuarial present value of the benefits accrued in prior years is the Funding Target of the participant. The Plan's Funding Target is the sum of each participant's Funding Target.

Funding Target (FT) is defined as the actuarial present value of benefits that have been accrued as of the valuation date

Target Normal Cost (TNC) is defined as the present value of all benefits that have accrued or are expected to be accrued during the plan year. Target Normal Cost also includes the plan-related expenses expected to be paid from Plan assets during the Plan Year.

Funding Shortfall is the excess (if any) of the Plan's Funding Target over the Plan's Asset Value, reduced by the Prefunding Balance and the Carryover Balance. Any experience gains or losses resulting from actual Plan experience, either more or less favorable than anticipated on the basis of actuarial assumptions and asset valuation method, will result in a decrease or increase in the Funding Shortfall.

The Carryover Balance (COB) is initially equal to the remaining funding standard account credit balance at PPA inception. It is increased with interest (actual return on assets) and reduced if used to satisfy the Minimum Required Contribution or to increase the Plan's funding status. This must be used before reductions in the Prefunding Balance.

The Prefunding Balance (PFB) may be increased annually by contributions made above the Minimum Required Contribution. It is increased with interest (actual return on assets) and reduced if used to satisfy the Minimum Required Contribution or to increase the Plan's funding status.