

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 07/01/2024 and ending 06/30/2025	
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 RETIREMENT PLAN FOR EMPLOYEES OF REDINGTON FAIRVIEW GENERAL HOSPITAL
1b	Three-digit plan number (PN) ▶ 001
1c	Effective date of plan 07/01/1987
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) REDINGTON-FAIRVIEW GENERAL HOSPITAL P.O. BOX 468 46 FAIRVIEW AVENUE SKOWHEGAN, ME 04976-0468
2b	Employer Identification Number (EIN) 01-0284446
2c	Plan Sponsor's telephone number 207-474-5121
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.	04/14/2026	DANA KEMPTON
	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	1282	
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) 723	
	6a(2) 661	6b 327	
	6c 275	6d 1263	
	6e 0	6f 1263	
	6g(1)	6g(2)	
	6h		
	7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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 0
- (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 07/01/2024 and ending 06/30/2025	
▶ 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 RETIREMENT PLAN FOR EMPLOYEES OF REDINGTON FAIRVIEW 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 REDINGTON-FAIRVIEW GENERAL HOSPITAL	D Employer Identification Number (EIN) 01-0284446
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 07 Day 01 Year 2024			
2	Assets:			
a	Market value	2a	96658364	
b	Actuarial value	2b	96658364	
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	327	29617343	29617343
b	For terminated vested participants	275	9206316	9206316
c	For active participants	661	30155858	31082122
d	Total	1263	68979517	69905781
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	5.42 %	
6	Target normal cost			
a	Present value of current plan year accruals	6a	2861385	
b	Expected plan-related expenses	6b	0	
c	Target normal cost	6c	2861385	

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 JONATHAN WITTEN Type or print name of actuary EPIC RETIREMENT PLAN SERVICES Firm name 5 WIDGERY WHARF 2ND FLOOR PORTLAND, ME 04101 Address of the firm	03/30/2026 Date 23-08824 Most recent enrollment number 207-879-9200 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	24186084
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	1781033
9 Amount remaining (line 7 minus line 8)	0	22405051
10 Interest on line 9 using prior year's actual return of <u>12.66</u> %	0	2836479
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		3248668
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> %		78372
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		225479
c Total available at beginning of current plan year to add to prefunding balance		3552519
d Portion of (c) to be added to prefunding balance		3552519
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	28794049

Part III Funding Percentages

14 Funding target attainment percentage	14	97.07 %
15 Adjusted funding target attainment percentage	15	138.26 %
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	87.75 %
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
05/15/2025	800000	0			
05/16/2025	400000	0			
10/17/2025	1500000	0			
01/27/2026	1000000	0			
01/28/2026	500000	0			
Totals ►			18(b)	4200000	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	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	3927095

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: 4.99 %	2nd segment: 5.29 %	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	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
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	2861385	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	2041466	224554	
b Waiver amortization installment	0	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	3085939	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	2681830	2681830
36 Additional cash requirement (line 34 minus line 35)	36	404109	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	3927095	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	3522986	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	2681830	
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 07/01/2024 and ending 06/30/2025		
A Name of plan	B Three-digit plan number (PN)	001
RETIREMENT PLAN FOR EMPLOYEES OF REDINGTON FAIRVIEW GENERAL HOSPITAL		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
REDINGTON-FAIRVIEW GENERAL HOSPITAL	01-0284446	

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
--

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--

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

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

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

CHARLES SCHWAB & CO.

94-1737782

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
72 19 27	CUSTODIAN	69993	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 ☐

(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:	WIPFLI LLP
b EIN:	39-0758449
c Position:	AUDITOR
d Address:	PO BOX 8010 WAUSAU, WI 54402-8010
e Telephone:	715-845-3111

Explanation: WIPFLI LLP COMPLETED A STRATEGIC INVESTMENT IN OCTOBER 2025, AND AS A RESULT HAS APPLIED FOR AND OBTAINED A NEW EIN. THERE HAS BEEN NO CHANGE IN AUDIT FIRM.

a Name:	MATTHEW PINE
b EIN:	16-1268674
c Position:	ENROLLED ACTUARY
d Address:	1610 DES PERES ROAD SUITE 203 ST. LOUIS, MO 63131
e Telephone:	314-721-8050

Explanation: NO LONGER EMPLOYED AT EPIC AS OF 5/2/2025.

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) 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 07/01/2024 and ending 06/30/2025		
A Name of plan RETIREMENT PLAN FOR EMPLOYEES OF REDINGTON FAIRVIEW GENERAL HOSPITAL		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 REDINGTON-FAIRVIEW GENERAL HOSPITAL		D Employer Identification Number (EIN) 01-0284446

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)	3900000	2700000
(2) Participant contributions.....	1b(2)		
(3) Other	1b(3)	138800	119129
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1700684	1580257
(2) U.S. Government securities	1c(2)	8030458	8658661
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	4143811	3881772
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	44099948	47470664
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	32761987	39410845
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)	2050032	3032960

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	96825720	106854288
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	96825720	106854288

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)	3900000	
(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)		3900000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	100479	
(B) U.S. Government securities	2b(1)(B)	172568	
(C) Corporate debt instruments	2b(1)(C)	209251	
(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)		482298
(2) Dividends: (A) Preferred stock.....	2b(2)(A)		
(B) Common stock	2b(2)(B)	833445	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	1398121	
(D) Total dividends. Add lines 2b(2)(A) , (B), and (C)	2b(2)(D)		2231566
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	10362823	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	9552660	
(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)	5553295	
(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)		99978
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		13077300

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	2978739	
(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)		2978739
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)	69993	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		69993
j Total expenses. Add all expense amounts in column (b) and enter total	2j		3048732

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		10028568
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **WIPFLI LLP**

(2) EIN: **41-2899048**

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?	☒		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		☒	
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 569609.

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 07/01/2024 and ending 06/30/2025					
A Name of plan RETIREMENT PLAN FOR EMPLOYEES OF REDINGTON FAIRVIEW GENERAL HOSPITAL				B Three-digit plan number (PN) ▶ 001	
C Plan sponsor's name as shown on line 2a of Form 5500 REDINGTON-FAIRVIEW GENERAL HOSPITAL				D Employer Identification Number (EIN) 01-0284446	
Part I Distributions					
All references to distributions relate only to payments of benefits during the plan year.					
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....				1 0	
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 01-6117334					
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 0	
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)..... 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)..... 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).....	14a 14b 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
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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: <u>74.8</u> % Private Equity: <u>0.0</u> % Investment-Grade Debt and Interest Rate Hedging Assets: <u>22.8</u> % High-Yield Debt: <u>0.0</u> % Real Assets: <u>0.0</u> % Cash or Cash Equivalents: <u>2.4</u> % Other: <u>0.0</u> % 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
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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 <u>02 / 28 / 2023</u> (MM/DD/YYYY) and the Opinion Letter serial number <u>Q704995A</u> .	

**Retirement Plan for Employees of Redington Fairview
General Hospital
EIN# 01-0284446; Plan # 001
Accountant's Opinion
Form 5500, Schedule H, Part III, Line 3
June 30, 2025**

The audit of the above named retirement plan is not yet complete. Upon completion of the audit, the Form 5500 will be amended to include a complete copy of the accountant's opinion, audited financial statements, and supplemental schedule(s).

Schedule SB, Line 26

Retirement Plan for Employees of Redington-Fairview General Hospital

EIN / PN: 01-0284446/ 001

Plan Year: 7/1/2024 to 6/30/2025

Schedule SB, line 26 - Schedule of Active Participant Data

Attained Age	Years of credited service																			
	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	
	Avg.		Avg.		Avg.		Avg.		Avg.		Avg.		Avg.		Avg.		Avg.		Avg.	
	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.	No.	Comp.
Under 25	9		20	40,784	0		0		0		0		0		0		0		0	
25 to 29	10		42	60,439	20	52,696	0		0		0		0		0		0		0	
30 to 34	14		40	79,765	17		16		2		0		0		0		0		0	
35 to 39	5		30	123,729	19		14		14		0		0		0		0		0	
40 to 44	6		17		14		12		10		4		0		0		0		0	
45 to 49	2		16		19		10		12		9		3		1		0		0	
50 to 54	3		18		9		13		15		9		0		2		1		0	
55 to 59	5		23	77,268	17		15		14		11		8		1		2		0	
60 to 64	4		11		7		7		10		6		4		4		3		3	
65 to 69	0		5		5		4		4		1		0		1		0		2	
70 & up	1		1		0		1		0		0		1		1		1		1	

FUNDING ASSUMPTIONS

Actuarial assumptions are estimates of the occurrence of future events affecting the costs of the plan such as mortality rates, changes in compensation levels, retirement ages, rates of investment earnings, expenses, etc. The assumptions have been chosen to anticipate the long-range experience of the plan. The enrolled actuary will certify to the reasonableness of these assumptions, as required by ERISA.

The actuarial assumptions used in this year's valuation are as follows:

Asset Method:	Market value	
Target Liability Interest Rates	ARPA Rates	PPA Rates
1 st Segment	4.99%	4.99%
2nd Segment	5.29%	5.29%
3rd Segment	5.59%	5.29%
Effective Rate¹	5.42% per annum	
Salary Increases:	4.50% per annum	
Mortality:	IRS 2024 Generational Mortality	
Turnover:	Watson Wyatt Termination Rates	
Retirement:	Watson Wyatt Retirement Rates	
Expenses in Target Normal Cost:	\$0 per annum	
Percent Married	100% of participants are assumed to be married	
Spouse Age Difference	Females are 3 years younger than males	
Assumed Forms of Benefit:	Life Annuity	100%

FUNDING METHODS

Valuation Date:	July 1, 2024
Asset Valuation	Plan assets are valued using fair market value of assets.
Liabilities	Liabilities are calculated using the traditional unit credit method in accordance with IRS section 430 and related guidance.

¹ The effective rate is the single rate that yields a liability equal to the liability calculated using the multiple rates shown above.

**Retirement Plan for Employees of Redington Fairview
General Hospital
EIN# 01-0284446; Plan # 001
Schedule of Reportable Transactions
Form 5500, Schedule H, Line 4(j)
Year Ended June 30, 2025**

The audit of the above named retirement plan is not yet complete. Upon completion of the audit, the Form 5500 will be amended to reflect the required supplemental schedules.

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 00/00/2020 and ending 06/30/2020	
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 R00R0M000000000R0M000000000R0D000000000R000000000R0000000000	B Three-digit plan number (PN) 000
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF R0D00000000R00000000R0000000000	D Employer Identification Number (EIN) 000200006
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 00 Day 00 Year 2020
2	Assets:
a	Market value 2a 0600360
b	Actuarial value 2b 0600360
3	Funding target/participant count breakdown
a	For retired participants and beneficiaries receiving payment (1) Number of participants 32 (2) Vested Funding Target 206003 (3) Total Funding Target 206003
b	For terminated vested participants (1) Number of participants 2 (2) Vested Funding Target 0206306 (3) Total Funding Target 0206306
c	For active participants (1) Number of participants 66 (2) Vested Funding Target 3000000 (3) Total Funding Target 3002022
d	Total (1) Number of participants 0263 (2) Vested Funding Target 6000000 (3) Total Funding Target 6000000
4	If the plan is in at-risk status, check the box and complete lines (a) and (b) 0
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 5 002 %
6	Target normal cost
a	Present value of current plan year accruals 6a 2060300
b	Expected plan-related expenses 6b 0
c	Target normal cost 6c 2060300

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	3/30/2026
Signature of actuary	Date
00000000 0000	23000200
Type or print name of actuary	Most recent enrollment number
0000R00R0M000000000R00000	020000000200
Firm name	Telephone number (including area code)
000 000R000 00R0	
20D00000R	
00R0000D0M000000	
Address of the firm	

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	200600
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	000033
9 Amount remaining (line 7 minus line 8)	0	220000
10 Interest on line 9 using prior year's actual return of <u>2.66</u> %	0	236000
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		320660
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>3</u> %		032
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		220000
c Total available at beginning of current plan year to add to prefunding balance		302000
d Portion of (c) to be added to prefunding balance		302000
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	200000

Part III Funding Percentages

14 Funding target attainment percentage	14	00 %
15 Adjusted funding target attainment percentage	15	3026 %
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	0000 %
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
00002020	000000	0			
00062020	000000	0			
00002020	000000	0			
00202026	000000	0			
00202026	000000	0			
Totals ▶			18(b)	200000	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	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	320000

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: □□□□ %	2nd segment: □2□ %	3rd segment: □□□□ %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 0
22 Weighted average retirement age				22 6□
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	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
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	2□6□3□□	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	20□□66	22□□□□	
b Waiver amortization installment	0	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	30□□3□	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	26□□30	26□□30
36 Additional cash requirement (line 34 minus line 35)	36	□0□□□	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	3□2□0□□	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	3□22□□6	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	26□□30	
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

Age	Expected Active Headcount	Retirement Rate	Expected Retirements	Weighted Age
60	370.52	0.13	47.47	2,848.33
61	333.72	0.13	42.13	2,569.87
62	300.30	0.17	51.97	3,222.04
63	257.24	0.13	33.35	2,100.78
64	235.83	0.13	30.16	1,930.53
65	214.73	1.00	214.73	13,957.24
66	7.00	1.00	7.00	462.00
67	3.00	1.00	3.00	201.00
68	2.00	1.00	2.00	136.00
69	5.00	1.00	5.00	345.00
70	1.00	1.00	1.00	70.00
71	2.00	1.00	2.00	142.00
72	1.00	1.00	1.00	72.00
73	-	1.00	-	-
74	2.00	1.00	2.00	148.00
75	-	1.00	-	-
76	-	1.00	-	-
77	1.00	1.00	1.00	77.00
Total			443.81	28,281.79
Average				63.73

Schedule SB, line 19 - Discounted Employer Contributions
Retirement Plan for Employees of Redington-Fairview General Hospital
EIN/PN: 01-0284446/001
Plan Year: 7/1/2024 to 6/30/2025

Schedule of Employer Contributions

Contribution Date	Contribution Amount	Interest Adjusted Contribution	Interest Adjusted Contribution w/ Late Quarterly Interest	Late Interest
Thu 5/15/2025	800,000	764,045	764,045	-
Fri 5/16/2025	400,000	381,967	381,967	-
Fri 10/17/2025	1,500,000	1,400,830	1,400,830	-
Tue 1/27/2026	1,000,000	920,213	920,213	-
Wed 1/28/2026	500,000	460,040	460,040	-
Total excluding CB:	4,200,000	3,927,095	3,927,095	-

Schedule SB, Part V – Summary of Plan Provisions
Retirement Plan for Employees of Redington-Fairview General Hospital
EIN / PN: 01-0284446/ 001
Plan Year: 7/1/2024 to 6/30/2025

PLAN PROVISIONS

Plan Name	Retirement Plan for Employees of Redington-Fairview General Hospital
Plan Year:	July 1 through June 30
Effective Dates:	Original Plan: July 1, 1987 Most Recent Amendment: January 1, 2012 Most Recent Restatement: January 1, 2020
Employee:	Any person employed by Redington-Fairview Hospital with scheduled hours of work.
Eligibility Requirements:	1,000 hours in first year of employment or subsequent Plan Year and attainment of age 21
Plan Entry Date:	An eligible employee will enter the plan on the first day of the month coinciding with or next following fulfilling eligibility requirements
Vesting Service:	An employee earns one year of Vesting Service for each Plan Year on or after July 1, 1987 in which he/she completes 1,000 or more hours of service. For Plan Years prior to July 1, 1987, Vesting Service is granted based on completed months of employment.
Benefit Service:	Benefit Service equals Vesting Service, except for the Past Service provision shown below and employees with no scheduled hours do not earn Benefit Service.
Past Service:	Service prior to July 1, 1987 is recognized as Benefit Service if the participant was an eligible employee on July 1, 1987.
Normal Retirement Date:	First day of the month coincident with or next following attainment of age 65.
Average Salary:	Average Salary is the participant's total compensation in the highest five consecutive calendar years during his/her last ten years of employment. Total compensation includes amounts contributed under a Section 403(b) salary reduction agreement, but not in excess of the compensation limit of \$200,000, as indexed after 2002.
Accrued Benefit:	The participant's benefit calculated as of the date of determination based on the Normal Retirement Benefit Formula payable at the Participant's Normal Retirement Date.
Normal Retirement Benefit:	The annual retirement benefit is equal to : 0.9% of Average Salary, plus 0.5% of Average Salary in excess of half the Taxable Wage Base; Multiplied by Years of Benefit Service, not in excess of 25.

PLAN PROVISIONS (CONTINUED)

Early Retirement Benefit:	Eligibility: Attainment of age 55 and completion of 10 Years of Vesting Service. Benefit: The early retirement benefit is equal to a participant's vested Accrued Benefit as of the date of termination, reduced by: 5/9ths of 1% for each of the first 60 months under age 65 plus 5/18ths of 1% for the next 60 months under age 60						
Deferred Retirement Benefit:	Eligibility: Continuation of employment beyond Normal Retirement Date. Benefit: The greater of the benefit computed based on service and salary earned as of the participant's actual retirement date, or the normal retirement benefit actuarially increased to reflect the period after Normal Retirement Age for which the participant did not receive benefits.						
Pre-Retirement Death Benefit:	Eligibility: Five years of Vesting Service Benefit: The spouse of a married participant shall receive a benefit equal to that which he/she would have received had the participant retired on the day preceding his/her death and chosen the 50% Joint and Survivor Annuity Option. The survivor annuity is payable on the later of the first day of the month coinciding with or next following the date of death or the participant's earliest retirement date. The beneficiary of an unmarried participant shall to receive the value of his or her benefit in a lump sum payment that is actuarially equivalent to the benefit computed as though the beneficiary is a spouse and is the same age as the participant.						
Vesting:	Participants will be vested in their accrued benefits, based on Years of Service, in accordance with the following schedule: <table><tr><td><u>Years of Service</u></td><td><u>Vesting Percent</u></td></tr><tr><td>Less than 5 years</td><td>0%</td></tr><tr><td>5 years or more</td><td>100%</td></tr></table>	<u>Years of Service</u>	<u>Vesting Percent</u>	Less than 5 years	0%	5 years or more	100%
<u>Years of Service</u>	<u>Vesting Percent</u>						
Less than 5 years	0%						
5 years or more	100%						
Forms of Benefit Payment:	a. Life Annuity (Normal form) b. 50% Joint and Survivor Annuity c. 66-2/3% Joint and Survivor Annuity d. 100% Joint and Survivor Annuity e. Ten-year Certain and Continuous Annuity						

**Retirement Plan for Employees of Redington Fairview
General Hospital
EIN# 01-0284446; Plan # 001
Schedule of Assets (Held at End of Year)
Form 5500, Schedule H, Part IV, Line 4(i)
June 30, 2025**

The audit of the above named retirement plan is not yet complete. Upon completion of the audit, the Form 5500 will be amended to reflect the Schedule of Assets (Held at End of Year) as required in the audited financial statements.

Attachment to Schedule SB, Line 32 — Shortfall Amortization Charge
Retirement Plan for Employees of Redington-Fairview General Hospital
EIN/PN: 01-0284446/001
Plan Year: 7/1/2024 to 6/30/2025

Development of Shortfall Amortization Charge

1. Funding target	69,905,781
2. Adjusted plan assets	
(a) Actuarial assets	96,658,364
(b) Funding Standard Carryover Balance	0
(c) Prefunding Balance (PFB)	28,794,049
(d) Adjusted assets: (a)-(b)-(c), not less than 0	67,864,315
3. Funding shortfall: (1)-(2)(d), not less than 0	2,041,466
4. Current shortfall amortization installments	
(i) Year -1 base (14 years remaining)	762,945
(ii) Year -2 base (13 years remaining)	0
(iii) Year -3 base (12 years remaining)	0
(iv) Year -4 base (11 years remaining)	0
(v) Year -5 base (10 years remaining)	0
(vi) Year -6 base (9 year remaining)	0
(vii) Year -7 base (8 year remaining)	0
(viii) Year -8 base (7 year remaining)	0
(ix) Year -9 base (6 year remaining)	0
(x) Year -10 base (5 year remaining)	0
(xi) Year -11 base (4 year remaining)	0
(xii) Year -12 base (3 year remaining)	0
(xiii) Year -13 base (2 year remaining)	0
(xiv) Year -14 base (1 year remaining)	0
(b) Total annual installments	762,945
(c) Present value of installments to be made	
(i) Year -1 base (14 years remaining)	7,824,974
(ii) Year -2 base (13 years remaining)	0
(iii) Year -3 base (12 years remaining)	0
(iv) Year -4 base (11 years remaining)	0
(v) Year -5 base (10 years remaining)	0
(vi) Year -6 base (9 year remaining)	0
(vii) Year -7 base (8 year remaining)	0
(viii) Year -8 base (7 year remaining)	0

(ix) Year -9 base (6 year remaining)	0
(x) Year -10 base (5 year remaining)	0
(xi) Year -11 base (4 year remaining)	0
(xii) Year -12 base (3 year remaining)	0
(xiii) Year -13 base (2 year remaining)	0
(xiv) Year -14 base (1 year remaining)	0
(d) Total present value of annual installments	7,824,974
5. If $(2a)-(5c) \geq (5b)$, then there is no need to establish a new base	
(a) Target liability percentage	100%
(b) Shortfall funding target: $(1) \times (a)$	69,905,781
(c) Prefunding Balance if used to reduce the MRC, else 0	28,794,049
6. Shortfall amortization base	
(a) Adjusted funding shortfall: $(5b)-(2d)$, not less than 0	2,041,466
(b) New current year base: $(a)-(4d)$, or 0 if exempt	-5,783,508
(c) New 15-year installment amount	-538,391
7. Shortfall amortization charge: $(4b)+(6c)$, not less than 0	224,554