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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

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.)
- [X] 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:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
JOHNSON SEWELL FORD LINCOLN 401K PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/1994

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)
JOHNSON SEWELL FORD LINCOLN LLC

3301 HWY 281 NORTH
MARBLE FALLS, TX 78654

2b Employer Identification Number (EIN)
74-2042138

2c Plan Sponsor's telephone number
830-693-5577

2d Business code (see instructions)
441110

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.	09/15/2026	MISTY KRISCH
	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 [X] 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

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	136
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	136
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	146
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	146
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f	Total. Add lines **6d** and **6e**.	**6f**	146
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	28
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	28
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

2E 2F 2G 2J 2T 3D

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

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] 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)** [X] 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)** [X] **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)** [X] **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 2025 Form M-1 annual report. If the plan was not required to file the 2025 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 I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
JOHNSON SEWELL FORD LINCOLN 401K PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
JOHNSON SEWELL FORD LINCOLN LLC

D Employer Identification Number (EIN)
74-2042138

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	3261153	3050009
b	Total plan liabilities	1b	0	0
c	Net plan assets (subtract line 1b from line 1a)	1c	3261153	3050009
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable:			
	(1) Employers	2a(1)	0	
	(2) Participants	2a(2)	155479	
	(3) Others (including rollovers)	2a(3)	0	
b	Noncash contributions	2b	0	
c	Other income	2c	456406	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		611885
e	Benefits paid (including direct rollovers)	2e	802059	
f	Corrective distributions (see instructions)	2f	18364	
g	Certain deemed distributions of participant loans (see instructions)	2g	0	
h	Administrative service providers (salaries, fees, and commissions)	2h	2606	
i	Other expenses	2i	0	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		823029
k	Net income (loss) (subtract line 2j from line 2d)	2k		-211144
l	Transfers to (from) the plan (see instructions)	2l		0

3 **Specific Assets:** If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	3a		X	0
b	Employer real property	3b		X	0
c	Real estate (other than employer real property)	3c		X	0
d	Employer securities	3d		X	0
e	Participant loans	3e	X		105588
f	Loans (other than to participants)	3f		X	0
g	Tangible personal property	3g		X	0

Part II Compliance Questions

4 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.)	4a		X	0
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

SCHEDULE R (Form 5500)

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

2025

This Form is Open to Public Inspection.

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
JOHNSON SEWELL FORD LINCOLN 401K PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
JOHNSON SEWELL FORD LINCOLN LLC

D Employer Identification Number (EIN)
74-2042138

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): 04-6568107

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

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

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) ..... | **6a** |

b Enter the amount contributed by the employer to the plan for this plan year ..... | **6b** |

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) ..... | **6c** |

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

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

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ 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 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q702438A .

ERISA DISHONESTY BOND

Edition of October 1, 2017

Policy No.
101960656

Merchants National Bonding, Inc.
(Herein called Company)

DECLARATIONS

Item 1. Name of Employee Benefit Plans (herein called Insured): Johnson Sewell Ford Lincoln 401(K) Plan

Principal Address: 3301 N US Highway 281
Marble Falls, TX 78654

Item 1a. Plan Sponsor Johnson Sewell Ford, LLC

Plan Sponsor Address: 3301 N US Highway 281, Marble Falls, TX 78654

Item 2. Policy Period: from 12:01 a.m. on August 1, 2026 (MONTH, DAY, YEAR) to 12:01 a.m. on August 1, 2029 (MONTH, DAY, YEAR)

Item 3. **INSURING AGREEMENT, LIMIT OF INSURANCE**

	Limit of Insurance Per Occurrence	**Deductible Per Occurrence**
1. Fraud or Dishonesty	$500,000.00	$0.00

Item 4. **ENDORSEMENTS FORMING PART OF THIS POLICY WHEN ISSUED**

FID 0150
FID 0165 TX, SUP 0032 TX

Item 5. **CANCELLATION OF PRIOR INSURANCE**

By acceptance of this Policy you give us notice cancelling prior policy Nos.

_____

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ERISA DISHONESTY BOND

Throughout this Policy the words "you" and "your" refer to the Insured(s) shown in the Declarations. The words "we", "us" and "our" refer to the Company providing this insurance. Read the entire Policy carefully to determine rights, duties and what is or is not covered. Words and phrases defined in the Policy are in **bold** type. This Policy's coverage is limited to the acts of **covered persons,** as defined in Definition C.2.

A. CONSIDERATION CLAUSE

In return for the payment of the premium, and subject to the Declarations, Insuring Agreement, Definitions, Exclusions, Conditions and other terms of this Policy, we will pay for loss covered by the Insuring Agreement of this Policy that you sustain resulting directly from acts committed or events occurring at any time and discovered by you during the Policy Period shown in the Declarations or during the period of time provided in the Extended Period to Discover Loss, Condition E.8.

B. INSURING AGREEMENT

Fraud or Dishonesty

We will pay for loss of **money, securities** or **other property** resulting directly from **fraud or dishonesty** committed by a **covered person**.

C. DEFINITIONS

1. **Cash** means United States or Canadian bills and coins in current use and having a face value that are accepted by the United States or by the government of Canada as legal tender for the payment of debts.
2. **Covered person** means any natural person who is
   a. a trustee, officer, employee, administrator or manager, except an administrator or manager who is an independent contractor, of any **employee benefit plan(s)** insured under this insurance; or
   b. a director, officer, employee or trustee of the Plan Sponsor, but only while that person is handling **money**, **securities** or **other property** of an **employee benefit plan** insured under this insurance;

   but does not include any agent, broker, person leased to you by a labor leasing firm, factor, commission merchant, consignee, independent contractor or representative of the same general character.
3. **Cryptocurrency** means a digital or electronic medium of exchange, operating independently of a central bank, in which encryption techniques are used to regulate the generation of units and to verify the transfer of such units from one person to another.
4. **Employee benefit plan(s)** means any welfare or pension benefit plan listed in the Declarations as an Insured that is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
5. **Fraud or dishonesty** means larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion or willful misapplication, or any other fraudulent or dishonest act, including acts prohibited by title 18, section 1954 of the U.S. Code.
6. **Money** means:
   a. **Cash**;
   b. Demand and savings deposits at financial institutions; and
   c. Travelers checks, register checks and money orders held for sale to the public.
7. **Occurrence** means all loss or losses caused by, or involving, any one **covered person**, acting alone or in collusion with others.
8. **Other property** means any tangible property other than **money** and **securities** that has intrinsic value but does not include any property excluded under this insurance.
9. **Securities** mean negotiable and nonnegotiable instruments or contracts representing either **money** or property and includes stocks, bonds, notes, repurchase agreements, commodities contracts and other instruments regularly bought and sold by broker dealers on stock or commodities exchanges, but does not include **money.**

D. EXCLUSIONS

We will not pay for loss as specified below:

1. Acts Committed by You

Loss resulting from any dishonest act committed by the Insured **employee benefit plan(s)** whether acting alone or in collusion with other persons. This exclusion does not affect coverage for loss under this Policy caused by the acts of **covered persons.**

2. Fire

Loss from damage to the premises resulting from fire, however caused.

3. Governmental Action

Loss resulting from seizure or destruction of property by order of governmental authority.

4. Indirect Loss

Loss that is an indirect result of any act or **occurrence** covered by this Policy including, but not limited to, loss resulting from:

a. Your inability to realize income that you would have realized had there been no loss;

b. Payment of damages of any type for which you are legally liable unless you establish that the act or acts that gave rise to the damages involved conduct which caused a covered loss of **money, securities** or **other property** which was in your custody and control and for which you were responsible prior to the loss; or

c. Payment of costs, fees or other expenses you incur in establishing either the existence or the amount of loss under this insurance.

5. Legal Expenses

Expenses related to any legal action.

6. Nuclear Chemical or Biological

Loss resulting from nuclear reaction, nuclear radiation or radioactive, chemical or biological contamination, or any related act or incident.

7. War and Similar Actions

Loss resulting from war, whether or not declared, warlike action, insurrection, rebellion or revolution, or any related act or incident.

8. Prior Dishonesty

Loss resulting from the dishonest or fraudulent acts of a **covered person** if you, or any employee, trustee, fiduciary or plan administrator of the Plan Sponsor or an Insured **employee benefit plan** who is not in collusion with such **covered person,** knows or knew prior to such loss of any prior dishonest or fraudulent act committed by such person, whether in the employment of the Plan Sponsor or any Insured **employee benefit plan** or otherwise, whether or not of the type covered under this Policy and without regard to whether the knowledge was obtained before or after the commencement of this Policy.

9. Inventory Shortages

Loss, or that part of any loss, the proof of which as to its existence or amount is dependent upon:

a. An inventory computation; or

b. A profit and loss computation.

However, where you establish wholly apart from such computations that you have sustained a loss, then you may offer your inventory records to support the amount of loss claimed.

10. Cryptocurrency

Loss resulting from the theft, disappearance or destruction of **cryptocurrency** or from the change in value of **cryptocurrency.**

11. Negligence

Loss resulting from the negligence of a **covered person**.

12. Confidential Information

Loss resulting from the theft, disappearance, destruction or disclosure of confidential information including, but not limited to, trade secrets, personal information, personally identifiable information, customer lists and intellectual property; provided however that this exclusion will not apply to loss that is otherwise covered under this Policy, caused by a **covered person's** access to, use of, or disclosure of confidential information to commit acts of **fraud or dishonesty**.

13. Data Breach Costs

Expenses related to your obligations to comply with federal and state privacy laws and Payment Card Industry Data Security Standards (if applicable) arising from a data security breach, including, but not limited to, expenses related to notifying affected individuals when the affected individuals' personally identifiable financial or medical information was stolen, accessed, downloaded or misappropriated while in your care, custody or control, forensic audit expenses and fines and penalties.

E. CONDITIONS

1. Cancellation

a. The Plan Sponsor shown in the Declarations may cancel this Policy by mailing or delivering to us advance written notice of cancellation.

b. We may cancel this Policy by mailing or delivering to the Plan Sponsor written notice of cancellation at least:

(1) 10 days before the effective date of cancellation if we cancel for nonpayment of premium; or

(2) 30 days before the effective date of cancellation if we cancel for any other reason.

c. We will mail or deliver our notice to the Plan Sponsor's last mailing address known to us.

d. Notice of cancellation will state the effective date of cancellation. The Policy Period will end on that date.

e. If this Policy is canceled, we will send the Plan Sponsor any premium refund due. If we cancel, the refund will be pro rata. If the Plan Sponsor cancels, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

f. If notice is mailed, proof of mailing will be sufficient proof of notice.

2. Changes

This Policy contains all the agreements between you and us concerning the insurance afforded. The Plan Sponsor shown in the Declarations is authorized on behalf of all insureds to agree with us on changes in the terms of this Policy. If the terms are changed, the changes will be shown in an endorsement issued by us and made a part of this Policy.

3. Concealment, Misrepresentation or Fraud

This Policy is void in any case of fraud by you as it relates to this Policy at any time. It is also void if any Insured or the Plan Sponsor, at any time, intentionally conceals or misrepresents a material fact concerning:

a. This insurance;

b. The covered property;

c. Your interest in the covered property; or

d. A claim under this insurance.

4. Consolidation and Merger

If through consolidation or merger with, or purchase or acquisition of assets or liabilities of, some other entity any additional persons become **covered persons**:

a. The Plan Sponsor must give us written notice and obtain our written consent to extend this Policy to such additional **covered persons**. We may condition our consent upon payment of an additional premium; but

b. For the first 60 days after the effective date of such consolidation, merger or purchase or acquisition of assets or liabilities, any insurance afforded for **covered persons** also applies to these additional **covered persons** for acts committed or events occurring within said 60 day period.

5. Discovery of Loss

Discovery of loss occurs when you or the Plan Sponsor first become aware of facts which would cause a reasonable person to assume that a loss covered by this Policy has been or will be incurred, even though the exact amount or details of the loss may not then be known. Discovery also occurs when you or the Plan Sponsor receive notice of an actual or potential claim against you alleging facts that if true would constitute a covered loss under this insurance.

6. Duties in the Event of Loss

After you or the Plan Sponsor discover a loss or a situation that may result in a loss you or the Plan Sponsor must:

a. Notify us as soon as possible;

b. Submit to examination under oath at our request and give us a signed statement of your answers;

c. Give us a detailed, sworn proof of loss within 120 days; and

d. Cooperate with us in the investigation and settlement of any claim.

7. Employee Benefit Plan(s)

a. It is the responsibility of you or the Plan Sponsor to select a Limit of Insurance for the Insuring Agreement that is sufficient to provide a limit that is at least equal to that required under ERISA if each **employee benefit plan** were separately insured.

b. Any payment we make to the Plan Sponsor for loss sustained by any **employee benefit plan** will be held by the Plan Sponsor for the use and benefit of the plan(s) sustaining the loss.

c. If two or more **employee benefit plans** are insured under this insurance, any payment we make for loss:

(1) Sustained by two or more **employee benefit plans**; or

(2) Of commingled **money, securities** or **other property** of two or more **employee benefit plans**;

that arises out of one **occurrence** and cannot be allocated specifically to any one **employee benefit plan**, is to be shared by each **employee benefit plan** sustaining loss in the proportion that the limit of insurance required under ERISA for each such **employee benefit plan** bears to the total of those limits.

8. Extended Period to Discover Loss

a. We will pay for loss that you sustained prior to the effective date of termination or cancellation of this insurance, which is discovered by you within one year following the date of termination or cancellation.

b. However, this extended period to discover loss terminates immediately upon the effective date of any other insurance obtained by you that offers the same coverage afforded by this Policy in an amount no less than the minimum amount required under ERISA section 412 and provides coverage for loss sustained prior to its effective date.

9. Joint Insured

a. The Plan Sponsor shown in the Declarations is responsible for the payment of all premiums and will be the payee for any return premiums we pay.

b. If more than one Insured is named in the Declarations, the Plan Sponsor may act for itself and for every other Insured for all purposes related to this insurance.

c. If the Plan Sponsor, any Insured or fiduciary of that Insured has knowledge of any information relevant to this insurance, that knowledge is considered knowledge of every Insured.

d. If this Policy or any of its coverage is canceled or terminated as to any Insured, Condition E.8. Extended Period to Discover Loss applies separately to that Insured.

10. Legal Action Against Us

You may not bring any legal action against us involving loss:

a. Unless you and the Plan Sponsor have complied with all the terms of this Policy; and

b. Until 90 days after you or the Plan Sponsor have filed proof of loss with us; and

c. Unless brought within 2 years from the date you or the Plan Sponsor discover the loss.

11. Liberalization

If we adopt any revision that would broaden the coverage under this Policy without additional premium within 45 days prior to or during the Policy Period, the broadened coverage will immediately apply to this insurance.

12. Limit of Insurance

The most we will pay for loss in any one **occurrence** is the Limit of Insurance shown in the Declarations.

13. Non-Cumulation of Limit of Insurance

Regardless of the number of years this Policy remains in force or the number of premiums paid, no Limit of Insurance cumulates from year to year or Policy Period to Policy Period.

14. Other Insurance

This Policy does not apply to loss recoverable or recovered under other insurance or indemnity. However, if the limit of the other insurance or indemnity is insufficient to cover the entire amount of the loss, this Policy will apply to that part of the loss not recoverable or recovered under the other insurance or indemnity.

15. Ownership of Property, Interests Covered

The property covered under this Policy is limited to property:

a. That you own or hold; or

b. That is owned and held by someone else under circumstances that made you responsible for the property prior to, and independent of, the loss.

However, this Policy is for your benefit only. It provides no rights or benefits to any other person or organization.

16. Records

You must keep records of all covered property so we can verify the amount of any loss.

17. Recoveries

a. Recoveries, whether effected by you or us, shall be applied, net of the expense of such recovery, in the following manner and order:

(1) To the satisfaction of your loss which would otherwise have been paid under this Policy but for the fact that it is in excess of the Limit of Insurance;

(2) Then to us, until we are reimbursed for the settlement made;

(3) Then to you for any loss not covered by this Policy.

b. Recoveries do not include any recovery from insurance, suretyship, reinsurance, security or indemnity taken for our benefit.

c. If original securities are recovered after duplicates of such securities have been issued, the original securities shall be surrendered to us.

18. Territory

This Policy covers only acts committed or events occurring within the United States of America, U.S. Virgin Islands, Puerto Rico or Canada. In addition, we will pay for loss caused by any **covered person** while temporarily outside of said territories for a period of not more than 90 days.

19. Transfer of Your Rights and Duties Under This Policy

Your rights and duties under this Policy may not be transferred without our written consent.

20. Transfer of Your Rights of Recovery Against Others to Us

You must transfer to us all your rights of recovery against any person or organization for any loss you sustained and for which we have paid or settled. You also must do everything necessary to secure those rights and do nothing after loss to impair our actual or potential rights of recovery.

21. Valuation — Settlement

a. Subject to the Limit of Insurance provision we will pay for:

(1) Loss of **money** but only up to and including its face value. We may, at our option, pay for loss of **money** issued by any country other than the United States of America:

(i) At face value in the **money** issued by that country; or

(ii) In the United States of America dollar equivalent determined by the rate of exchange on the day the loss was discovered.

(2) Loss of **securities** but only up to and including their value at the close of business on the day the loss was discovered. We may, at our option:

(i) Pay the value of such **securities**, or replace them in kind, in which event you must assign to us all your rights, title and interest in and to those **securities**; or

(ii) Pay the cost of any lost securities bond required in connection with issuing duplicates of the **securities**. However, we will be liable only for the payment of so much of the cost of the bond as would be charged for a bond having a penalty not exceeding the lesser of the:

(a) Value of the **securities** at the close of business on the day the loss was discovered; or

(b) Limit of Insurance.

(3) Loss of, or loss from damage to **other property**. However, we will not pay more than the least of the following:

(i) The Limit of Insurance applicable to the lost or damaged property;

(ii) The cost to replace the lost or damaged property with property:

(a) Of comparable material and quality; and

(b) Used for the same purpose; or

(iii) The amount you actually spend that is necessary to repair or replace the lost or damaged property.

(4) We will not pay on a replacement cost basis for any loss or damage:

(i) Until the lost or damaged property actually is repaired or replaced; and

(ii) Unless the repairs or replacement are made as soon as reasonably possible after the loss or damage.

If the lost or damaged property is not repaired or replaced, we will pay on an actual cash value basis.

b. We may, at our option, pay for loss of, or loss from damage to, property other than **money**:

(1) In the **money** of the country in which the loss occurred; or

(2) In the United States of America dollar equivalent of the **money** of the country in which the loss occurred determined by the rate of exchange on the day the loss was discovered.

c. Any property that we pay for or replace becomes our property.

22. Cancellation as to Any Covered Person

Coverage under this Policy is canceled as to any **covered person**:

a. Immediately upon discovery by any Insured **employee benefit plan**, or by any employee, trustee, fiduciary or plan administrator of such an Insured **employee benefit plan** or Plan Sponsor who is not in collusion with the **covered person**, of any dishonest act committed by that **covered person** whether before or after becoming a **covered person**. Whether such discovery occurs prior to or after commencement of this Policy, there is no coverage under the Insuring Agreement for loss or losses resulting from acts committed by that **covered person** after the date of such discovery.

b. On the date specified in a notice mailed to you. That date will be at least 30 days after the date of mailing. The mailing of notice to you at the last mailing address of the Plan Sponsor known to us will be sufficient proof of notice. Delivery of notice is the same as mailing.

23. **Deductible**

The deductible set forth in the Declarations shall be applicable to a loss suffered by an **employee benefit plan** only after that **employee benefit plan** has received from us:

a. $500,000; or

b. $1,000,000, if the **employee benefit plan** holds "employer securities" within the meaning of section 407(d)(1) of ERISA.

IN WITNESS WHEREOF, we have caused this Policy to be executed on the Declarations page.

Attested By:

By: _____
Elisabeth Sandersfeld, Secretary

By: _____
Larry Taylor, President

MERCHANTS NATIONAL BONDING, INC.
INCORPORATED
-o-
2003

MERCHANTS BONDING COMPANY™

MERCHANTS NATIONAL BONDING, INC. P.O. BOX 14498, DES MOINES, IA 50306-3498
PHONE: (800) 678-8171 FAX: (515) 243-3854

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.
ERISA INFLATION GUARD

This Endorsement modifies ERISA Dishonesty Bond No. 101960656

If the Fraud or Dishonesty Insuring Agreement Limit of Insurance indicated on Item 3. of the Declarations of this Policy, or amendment thereof no longer complies with the minimum amount of coverage required for **Employee Benefit Plan(s)** under ERISA, we agree to automatically increase such Limit of Insurance with regard to such **Employee Benefit Plan(s)** to equal the minimum amount of coverage required under ERISA at the beginning of the **Employee Benefit Plan(s)** fiscal year or $500,000, whichever is less.

The increased Limit of Insurance afforded by this endorsement will only apply if the Fraud or Dishonesty Insuring Agreement Limit of Insurance provided coverage in an amount that was equal to or greater than the minimum amount required under ERISA at the time the Policy was issued or renewed.

MERCHANTS BONDING COMPANY™

MERCHANTS NATIONAL BONDING, INC. P.O. BOX 14498, DES MOINES, IA 50306-3498
PHONE: (800) 678-8171 FAX: (515) 243-3854

NOTICE TO BOND HOLDER – RETAIN THIS PAGE FOR YOUR RECORDS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

To get information or file a complaint with your insurance company or HMO:

Merchants National Bonding, Inc.

Call: Compliance Officer at (800) 678-8171
Toll-free: (800) 678-8171
Email: regulatory@merchantsbonding.com
Mail: P.O. Box 14498, Des Moines, IA 50306-3498

To get insurance information, you may also contact your agent:

Select Insurance Solutions

Call: 512-763-4650

Mail: 3550 Lakeline Blvd, Suite 170-1804 Leander, TX 78641

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Merchants National Bonding, Inc.
Llame a: Compliance Officer al (800) 678-8171
Teléfono gratuito: (800) 678-8171
Correo electrónico: regulatory@merchantsbonding.com
Dirección postal: P.O. Box 14498, Des Moines, IA 50306-3498

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS CHANGES - CANCELLATION AND NONRENEWAL

This Endorsement modifies ERISA Dishonesty Bond No. 101960656.

1. The **Cancellation** condition is deleted and replaced by the following:

a. The Plan Sponsor shown in the Declarations may cancel this Policy by mailing or delivering to us written notice of cancellation.

b. If this Policy has been in effect for fewer than 90 days and is not a renewal of a policy we issued, we may cancel this Policy for any reason.

(1) We may cancel this Policy for non-payment of premium by mailing or delivering to the Plan Sponsor written notice of cancellation at least 10 days before the effective date of cancellation.

(2) We may cancel this Policy for any reason other than non-payment of premium by mailing or delivering to the Plan Sponsor written notice of cancellation at least 30 days before the effective date of cancellation.

c. If this Policy has been in effect for 90 days or more, or is a renewal of a policy we issued, we may cancel only for one or more of the following reasons:

(1) Nonpayment of premium;

(2) Submission of a fraudulent claim by you;

(3) Increase in hazard within your control which would produce an increase in rate; or

(4) Determination by the Department of Insurance that continuation of this Policy would violate or place us in violation of the Insurance Code.

d. We will mail or deliver written notice of cancellation pursuant to subparagraph **c.** to the Plan Sponsor at least 10 days before the effective date of cancellation.

e. Notice of cancellation will state the effective date of cancellation. The Policy Period will end on that date.

2. The following Condition is added to the Policy.

NONRENEWAL

If we decide not to renew this Policy, we will mail or deliver written notice of nonrenewal to the Plan Sponsor, at least 30 days before its expiration date, or its anniversary date if it is a policy written for a term of more than one year or with no fixed expiration date.

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THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS CHANGES

This Endorsement modifies ERISA Dishonesty Bond No. _____101960656_____.

1. The **Legal Action Against Us** condition is replaced by the following:

Legal Action Against Us

You may not bring any legal action against us involving loss more than 2 years and 1 day after the earlier of (a) the date you or the Plan Sponsor gave us the initial proof of loss or (b) 120 days after discovery of the loss.

2. The following Condition is added to the Policy:

We may not cancel or refuse to renew this Policy based solely on the fact that the policyholder is an elected official.