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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 04/01/1987

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)
MARY FREE BED REHABILITATION HOSPITAL

235 WEALTHY SE
GRAND RAPIDS, MI 49503-5299

2b Employer Identification Number (EIN) 38-1359265

2c Plan Sponsor's telephone number 616-840-8361

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.	09/24/2026	RANDI BOWERS PAYNE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/24/2026	RANDI BOWERS PAYNE
	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**	3332
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)**	2361
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	2663
b	Retired or separated participants receiving benefits	**6b**	347
c	Other retired or separated participants entitled to future benefits	**6c**	559
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	3569
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	3
f	Total. Add lines **6d** and **6e**.	**6f**	3572
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)**	3294
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)**	3424
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	411
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:

2F 2G 2L 2M 2T

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)** [X] 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)** [X] 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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 6
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **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 A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	707047	3	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	38818
5	Current value of plan's interest under this contract in separate accounts at year end	5	13297

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☒ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	39234
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	1171		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	1171
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	40405
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1581		
	(2) Administration charge made by carrier	7e(2)	6		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	1587
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	38818

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	075746	5	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	87124
5	Current value of plan's interest under this contract in separate accounts at year end	5	409424

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b	Balance at the end of the previous year			7b	87995
c	Additions: (1) Contributions deposited during the year	7c(1)	0		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	2627		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below) ▶	7c(5)			
	(6) Total additions			7c(6)	2627
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	90622
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	3497		
	(2) Administration charge made by carrier	7e(2)	1		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below) ▶	7e(4)			
	(5) Total deductions			7e(5)	3498
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	87124

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65676	CR21475	2	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
1892	0

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

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

LINCOLN FINANCIAL ADVISORS
PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
1892			4

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	500889
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP VARIABLE ANNUITY W/GUAR

b	Balance at the end of the previous year			7b	504461
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	16960		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	16960
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	521421
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	20507		
	(2) Administration charge made by carrier	7e(2)	25		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	20532
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	500889

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65676	CR34160	15	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
2555	0

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

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

LINCOLN FINANCIAL ADVISORS
PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2555			4

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	266527
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP VARIABLE ANNUITY W/GUAR

b	Balance at the end of the previous year			7b	237869
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	14523		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)	44550		
	▶ LOAN REPAYMENTS, ADJUSTEMENTS				
	(6)Total additions			7c(6)	59073
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	296942
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	5224		
	(2) Administration charge made by carrier	7e(2)	49		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)	25132		
	▶ LOANS ISSUED, FEES, CORRECTIONS				
	(5) Total deductions			7e(5)	30405
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	266537

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65676	GP01015	21	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
2491	0

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

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

LINCOLN FINANCIAL ADVISORS
PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2491			4

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	217612
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP VARIABLE ANNUITY W/GUAR

b	Balance at the end of the previous year			7b	212573
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	7380		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	7380
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	219953
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0		
	(2) Administration charge made by carrier	7e(2)	42		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)	2299		
	▶ MAY INCLUDE LOAN ISSUED, FORFEITURE				
	(5) Total deductions			7e(5)	2341
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	217612

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	1095023	15	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
190	0

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

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

LINCOLN INVESTMENT PLANNING LLC
601 OFFICE CENTER DRIVE STE 300
FORT WASHINGTON, PA 19034

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
190			4

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	85887
5	Current value of plan's interest under this contract in separate accounts at year end	5	500892

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP DEFERRED ANNUITIES

b	Balance at the end of the previous year			7b	83100
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	2820		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	2820
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	85920
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)	33		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	33
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	85887

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

EQUITABLE FINANCIAL LIFE INS COMPAN

13-5570651

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

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

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

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

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

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

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

EMPOWER ANNUITY INSURANCE COMPANY
8515 EAST ORCHARD ROAD
GREENWOOD, CO 80111

(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?
65 64	CONTRACT ADMINISTRATOR	351959	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: POOLED SEPARATE ACCOUNT 48

b Name of sponsor of entity listed in (a): EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
13-5570651-000	P	422721

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

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a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

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)	1947131	2895073
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	1066654	867420
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	590959	422721
(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)	153149269	183070735
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	1165232	1196857
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	157919245	188452806
Liabilities			
1g Benefit claims payable	1g		
1h Operating payables	1h		
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k		
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	157919245	188452806

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)	7426006	
(B) Participants	2a(1)(B)	11162381	
(C) Others (including rollovers)	2a(1)(C)	1713895	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		20302282
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	85173	
(F) Other	2b(1)(F)	45482	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		130655
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	10081202	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		10081202
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		124922
(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)		14756393
c Other income	2c		17230
d Total income. Add all **income** amounts in column (b) and enter total	2d		45412684
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	14485021	
(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)		14485021
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		40315
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	353787	
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		353787
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		14879123
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		30533561
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: HUNGERFORD **(2)** EIN: 38-2184825

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.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this 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 have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
MARY FREE BED REHABILITATION HOSPITAL

D Employer Identification Number (EIN)
38-1359265

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): 84-1455663

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 11 / 29 / 2024 (MM/DD/YYYY) and the Opinion Letter serial number Q705901A .

MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

FINANCIAL STATEMENTS

For the years ended
December 31, 2025 and 2024

HUNGERFORD
CPAs • ADVISORS • TECHNOLOGY • WEALTH

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HUNGERFORD
CPAs • ADVISORS • TECHNOLOGY • WEALTH

INDEPENDENT AUDITOR'S REPORT

September 24, 2026

To the Plan Administrator of the
Mary Free Bed Rehabilitation Hospital 403(b) Plan
Grand Rapids, Michigan

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

We were engaged to perform audits of the financial statements of Mary Free Bed Rehabilitation Hospital 403(b) Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statements of assets available for benefits as of December 31, 2025, and 2024 and the related statements of changes in assets available for benefits for the years then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of Mary Free Bed Rehabilitation Hospital 403(b) Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from qualified institutions as of and for the years ended December 31, 2025, and 2024 stating that the certified investment information, as described in Note E to the financial statements, is complete and accurate.

Disclaimer of Opinion

We do not express an opinion on the accompanying financial statements of Mary Free Bed Rehabilitation Hospital 403(b) Plan. Because of the significance of the matters described in the *Basis for Disclaimer of Opinion* section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the financial statements.

Basis for Disclaimer of Opinion

Mary Free Bed Rehabilitation Hospital 403(b) Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009. Accordingly, we were unable to apply auditing procedures sufficient to determine the extent to which the accompanying financial statements may have been affected by these conditions.

Further, as described in Note B to the financial statements, Mary Free Bed Rehabilitation Hospital 403(b) Plan has excluded from investments in the accompanying statement of assets available for benefits certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009, as permitted by the Department of Labor's Field Assistance Bulletin No. 2009-02, Annual Reporting Requirements for 403(b) Plans. The investment income and distributions related to such accounts have also been excluded in the accompanying statements of changes in assets available for benefits. The amount of these excluded annuity contracts and custodial accounts and the related income and distributions are not reasonably determinable. Accounting principles generally accepted in the United States of America require that these accounts and the related income and distributions be included in the accompanying financial statements.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Mary Free Bed Rehabilitation Hospital 403(b) Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our responsibility is to conduct an audit of Mary Free Bed Rehabilitation Hospital 403(b) Plan's financial statements in accordance with auditing standards generally accepted in the United States of America and to issue an auditor's report. However, because of the matters described in the *Basis for Disclaimer of Opinion* section of our report, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these financial statements.

We are required to be independent of Mary Free Bed Rehabilitation Hospital 403(b) Plan, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits.

Supplemental Schedule Required by ERISA

The supplemental Schedule of Assets (Held at End of Year) as of December 31, 2025 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. Because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our report, it is inappropriate to, and we do not express an opinion on the supplemental schedule referred to above.



Certified Public Accountants
Grand Rapids, Michigan

FINANCIAL STATEMENTS

STATEMENTS OF ASSETS AVAILABLE FOR BENEFITS

MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN
December 31, 2025 and 2024

	2025	2024
Assets		
Investments at fair value:		
Mutual funds	$ 182,569,843	$ 152,709,762
Pooled separate accounts	923,613	1,030,466
Investments at contract value:		
Insurance company unallocated contracts	1,196,857	1,165,232
Total investments	184,690,313	154,905,460
Receivables:		
Employer contribution receivable	2,895,073	1,947,131
Notes receivable from participants	867,420	1,066,654
Total receivables	3,762,493	3,013,785
Assets Available for Benefits	**$ 188,452,806**	**$ 157,919,245**

STATEMENTS OF CHANGES IN ASSETS AVAILABLE FOR BENEFITS

MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

For the years ended December 31, 2025 and 2024

	2025	2024
Additions to Assets Attributed to:		
Investment income:		
Interest and dividends	$ 10,126,684	$ 6,273,131
Net appreciation in fair value of investments	14,881,315	11,343,805
Other income	17,230	41,473
Total investment income	25,025,229	17,658,409
Interest income on notes receivable from participants	85,173	66,639
Contributions:		
Employer	7,426,006	6,160,997
Participant	11,162,381	9,897,201
Rollover	1,713,895	2,833,566
Total contributions	20,302,282	18,891,764
Total Additions	45,412,684	36,616,812
Deductions from Assets Attributed to:		
Benefits paid to participants	14,525,336	15,683,107
Administrative expenses	353,787	363,510
Total Deductions	14,879,123	16,046,617
Net Increase	30,533,561	20,570,195
Assets Available for Benefits:		
Beginning of year	157,919,245	137,349,050
End of year	**$ 188,452,806**	**$ 157,919,245**

Note A – Description of Plan

The following description of Mary Free Bed Rehabilitation Hospital 403(b) Plan (Plan) provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution 403(b) plan covering substantially all employees of Mary Free Bed Rehabilitation Hospital (Organization), the Plan's sponsor. Eligible employees can become participants in the Plan and become eligible to receive employer contributions on the employee's date of employment. Any person who becomes an employee as a result of an acquisition will receive credit for service with the prior employer during the plan year of the acquisition. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Participants may elect to make pre-tax contributions or after-tax Roth contributions to the Plan through payroll deductions from each participant's compensation, as defined, subject to statutory limitations. Upon satisfying eligibility requirements, employees are automatically enrolled in the Plan at a rate of 3% of eligible compensation, unless they elect otherwise. Participants that meet certain criteria are eligible to make catch-up contributions to the Plan. The Plan also allows participants to transfer funds from other qualified plans into the Plan.

The Organization may elect to make discretionary matching contributions. Matching contributions are made based on pay deferral contributions made on behalf of each participant who has completed one year of service with at least 1,000 hours and is employed on the last day of the plan year. The Organization made matching contributions of 50% of employee deferrals up to 6% deferred by each participant for the years ended December 31, 2025 and 2024.

The Organization also makes a non-elective contribution to the Plan that is based upon each participant's compensation and years of benefit service. For the plan years ended December 31, 2025 and 2024, the calculation was as follows:

Participant's Years of Benefit Service	**Percentage of Participant's Compensation**
Less than 5 years	2%
At least 5 years, but less than 10 years	3%
At least 10 years, but less than 15 years	4%
15 or more years	5%

Note A – Description of Plan (Continued)

Contributions (Continued)

Participants working as physicians as part of the Mary Free Bed Medical Group will receive a non-elective contribution of 5% of compensation, regardless of their years of service. In order to receive the employer non-elective contribution, a participant must be employed on the last day of the plan year and have at least 1,000 hours of service during that plan year.

In addition, eligible participants may receive a "transition" contribution in an amount equal to 3% of the participant's compensation, based on eligibility conditions contained in the plan document.

Plan Operations

The Organization has appointed Empower Trust Company, LLC, The Lincoln National Life Insurance Company, Fidelity Management Trust Company, Metropolitan Life Insurance Company, and Equitable Financial Life Insurance Company (Certifying Entities) to serve as custodians of the Plan's assets. These entities are responsible for holding investment assets of the Plan, executing investment transactions, and making distributions to participants. The Organization acts as plan administrator. The plan administrator interprets and communicates the provisions of the Plan and ensures that all government and participant reporting requirements are fulfilled. The Plan's fiduciary committee is responsible for oversight of the Plan, determines the appropriateness of the Plan's investment strategy, and monitors investment performance.

Participant Accounts

Individual accounts are maintained for each participant, with benefits limited to the amount contributed to the participant's account plus or minus any allocation of income, expenses, gains, or losses. Allocations to participant accounts are based on compensation or account balances, as specified by the plan document. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

The Plan allows a participant to self-direct investment transactions associated with separate investment fund options made available by the employer for this purpose.

Vesting

Participants are immediately 100% vested in their deferral and rollover contribution accounts. Company contribution accounts are fully vested upon three years of service, as defined by the Plan. A participant also becomes fully vested if the participant dies or becomes disabled while employed or upon attainment of normal retirement age.

Note A – Description of Plan (Continued)

Loans to Participants

Under certain conditions, a participant may obtain a loan from the Plan. A participant may borrow a minimum of $1,000 up to a maximum of the lesser of $50,000, reduced by the participant's highest outstanding loan balance during the 12-month period before the loan is made, or one half of the participant's interest in the Plan. The loan will bear interest at a reasonable rate, be adequately secured, and not exceed a period of five years (unless secured by a principal residence). Principal and interest repayments are directly from the participant's bank accounts.

Payment of Benefits

On termination of service, a participant may elect to receive a lump sum payment equal to the vested interest in his or her account or installment payments. In-service withdrawals are also permitted after having attained age 59½ or in cases of financial hardship.

Costs and Expenses

Certain transaction fees and other administrative expenses are paid by the Plan and are based on reasonable and customary rates. Certain other costs and expenses incurred in connection with the operation of the Plan are borne by the Organization.

Forfeited Accounts

Forfeited balances may be used to pay reasonable administrative expenses of the Plan or to reduce employer contributions. The balance in the Plan's forfeiture account as of December 31, 2025 and 2024 was $353,634 and $905,786, respectively. Forfeitures of $1,303,511 and $145,693 were used as allowed by the Plan for the years ended December 31, 2025 and 2024, respectively.

Note B – Summary of Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared using the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Accordingly, actual results could differ from those estimates.

Note B – Summary of Accounting Policies (Continued)

Investment Valuation and Income Recognition

Investments are reported in the Plan's financial statements at fair value, except for fully benefit-responsive investment contracts, which are reported at contract value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note C for discussion of fair value measurements.

Contract value is the relevant measurement for assets invested in fully-benefit responsive investment contracts because contract value is the amount participants normally would receive if they were initiate permitted transactions under the terms of the Plan.

Income from interest is recorded as it is earned. Dividends are recorded on the ex-dividend date. Purchases and sales of securities are recorded on a trade date basis. Net appreciation or depreciation of investments is determined using the value at the beginning of the year or purchase price if acquired since that date. Management fees and operating expenses charged to the Plan for investments in mutual funds and pooled separate accounts are deducted from income earned on a daily basis and are not separately reflected. Consequently, management fees and operating expenses are reflected as a reduction of investment return for such investments.

Excluded Contracts

The plan administrator has elected to exclude certain contracts and accounts from plan assets in accordance with Department of Labor's Field Assistance Bulletin 2009-02 due to the following:

- the contract or account was issued to a current or former employee before January 1, 2009,
- the employer ceased to have any obligation to make contributions (including employee salary reduction contributions), and in fact, stopped making contributions to the contract or account before January 1, 2009,
- all the rights under the contract or account are legally enforceable against the insurer by the individual owner of the contract or account without any involvement by the employer,
- the individual owner of the contract should be fully vested in the contract or account.

Because the plan administrator has elected to exclude certain contracts in accordance with Department of Labor's Field Assistance Bulletin 2009 02, the excluded contracts are not in accordance with accounting principles generally accepted in the United States of America (GAAP) and, accordingly, it is not intended that these financial statements be presented in accordance with GAAP.

Benefits

Benefits are recorded when paid.

Note B – Summary of Accounting Policies (Continued)

Notes Receivable from Participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest is recorded on the accrual basis. Related fees are charged directly to the participant's account and are included in administrative expenses when incurred. Delinquent notes receivable from participants are recorded as a distribution based upon the terms of the plan document; therefore, an allowance for credit losses is not considered necessary at December 31, 2025 and 2024.

Subsequent Events

Management evaluates events occurring subsequent to the date of the financial statements in determining the accounting for and disclosure of transactions and events that affect the financial statements. Subsequent events have been evaluated through September 24, 2026, which is the date the financial statements were available to be issued.

Note C – Fair Value Measurements

The Plan's investments, except those that are required to be reported at contract value, are reported at fair value in the accompanying statements of assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The fair value measurement accounting literature establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described as follows:

Level 1 – inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the Plan has the ability to access.

Level 2 – inputs to the valuation methodology include:

- quoted prices for similar assets and liabilities in active markets,
- quoted prices for identical or similar assets and liabilities in markets that are not active,
- other inputs that are observable or can be corroborated by observable market data,
- inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Note C – Fair Value Measurements (Continued)

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – inputs are generally unobservable and significant to the fair value measurement. Such inputs typically reflect management's estimates of assumptions that market participants would use in pricing the asset or liability, including certain pricing models, discounted cash flow methodologies and similar techniques that use significant unobservable inputs.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for investments measured at fair value. There have been no changes in the methodologies used at December 31, 2025 and 2024.

Mutual funds: Valued based on quoted net asset values (NAV) of the shares held by the Plan on the last business day of the plan year.

Pooled separate accounts: Valued at NAV based on the closing price for underlying securities, reported on the active market on which underlying securities are traded or based on quoted prices of similar assets. The NAV of each of the separate accounts is reported daily by the fund managers as based on recent transaction prices and represents the price at which the Plan would be able to initiate a transaction. The pooled separate accounts held by the Plan provide for daily redemptions by the Plan at reported NAV with no advance notice requirement and have no unfunded commitments.

The following tables set forth by level, within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2025 and 2024:

	Level 1	Level 2	Level 3	Total
December 31, 2025				
Mutual funds	$ 182,569,843	$ -	$ -	$ 182,569,843
Pooled separate accounts	-	923,613	-	923,613
	$ 182,569,843	$ 923,613	$ -	$ 183,493,456
December 31, 2024				
Mutual funds	$ 152,709,762	$ -	$ -	$ 152,709,762
Pooled separate accounts	-	1,030,466	-	1,030,466
	$ 152,709,762	$ 1,030,466	$ -	$ 153,740,228

Note D – Investment Contracts with Insurance Companies

Plan assets include benefit-responsive group annuity fixed income contracts issued by the Lincoln National Life Insurance Company, Metropolitan Life Insurance Company, and Equitable Financial Life Insurance Company. The methodology for calculating the interest crediting rate is defined in the terms of the contracts. Under terms of the existing contracts, the crediting rate is generally reset on a quarterly basis and will generally never be less than 1.75%.

As described above, because the fixed income contracts are fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the assets available for benefits attributable to the contract. Contract value, as reported to the Plan by the issuers, represents contributions made under the contract, plus earnings at guaranteed crediting rates, less participant withdrawals and fees. There are not any events that could limit the ability of the Plan to transact at contract value paid within twelve months. There are not any events that allow the issuer to terminate the contract which would require the plan sponsor to settle at an amount different than contract value paid within twelve months. Participants may ordinarily direct permitted withdrawal or transfer of all or a portion of their investment at contract value within reasonable timeframes.

By definition, the fixed income contracts are insurance contracts. As a result, the Plan may transact or terminate the contracts according to the terms defined in the contracts at any time.

Note E – Information Certified by Certifying Entities

All investment information disclosed in the accompanying financial statements and supplemental schedule, including investments held and notes receivable from plan participants at December 31, 2025 and 2024, and net appreciation in fair value of investments, interest and dividends, interest income on notes receivable from participants, and other income for the years ended December 31, 2025 and 2024, were obtained or derived from information supplied to the plan administrator and certified as complete and accurate by the Certifying Entities.

Note F – Risks and Uncertainties

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

Note G – Party-In-Interest Transactions

Plan investments include investments managed by affiliates of the Plan custodians and insurance contract holders. As defined by the Plan, these transactions qualify as party-in-interest transactions.

Fees paid by the Plan to parties-in-interest for services rendered to the Plan were $353,787 and $363,510 for the years ended December 31, 2025 and 2024, respectively. Such fees were based on reasonable and customary rates.

In addition, the Plan maintains notes receivable from participants. These party-in-interest transactions are exempt from the prohibited transaction rules under ERISA.

Note H – Plan Termination

Although it has not expressed any intent to do so, the Organization has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of plan termination, participants would become 100 percent vested in their accounts.

Note I – Tax Status

The pre-approved plan used by the Plan obtained an opinion letter dated November 29, 2024, in which the Internal Revenue Service stated that the pre-approved plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has not requested or received an individual determination letter. However, the plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2025, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax period in progress. The plan administrator believes it is no longer subject to income tax examinations for years prior to 2022.

Note J – Subsequent Amendment

Effective January 1, 2026, the Plan document was amended to discontinue the "transition" contribution provision.

SUPPLEMENTAL SCHEDULE

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

MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN
December 31, 2025
EIN 38-1359265
PN 002

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost **	(e) Current Value
	Equitable Financial:			
*	Equitable Investment Management	EQ/COM Stock Index		$ 322,375
		1290 VT GAMCO Small Co Val		55,092
		Guaranteed Interest Account		125,941
		EQ/Balanced Strategy		41,723
		Multimanager Aggressive Equity		129
		EQ/Lg Cap Val Managed Vol		32
		EQ/AB Small Cap Growth		70
		EQ/International Equity Index		59
		EQ/Int Core Managed Vol		41
		1290 VT Small Cap Value		57
		Target 2035 Allocation		3,144
	See attached schedules for additional investments and participant loans held by others.			$185,009,070

* Indicates party-in-interest
** Not required for participant directed accounts

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
1TFRRX			59,433.23	59,626.57
1TORFX			47,022.35	47,746.53
1TTRTX			890,280.11	894,792.86
1TTURX			2,101,362.87	2,159,056.25
1TRVVX			5,813,435.29	6,142,245.56
1TWRRX			13,588,188.80	15,019,163.75
1TPGPX			16,412,702.31	18,927,994.65
1TRXRX			12,410,335.04	14,948,355.75
1TRFWX			13,175,063.99	16,425,465.80
1TOORX			17,705,395.59	22,415,658.50
1TRPPX			13,661,223.40	17,148,634.77
1TTOIX			9,474,468.30	11,405,113.84
1RPFDX			2,300,420.18	2,528,336.15
1RERGX			4,664,001.87	4,864,649.00
1VWILX			2,912,223.43	2,982,382.28
1ABSAX			943,905.07	891,570.73
1TQAIX			1,709,660.14	1,822,995.83
1FSMAX			1,961,657.08	2,417,427.67
1JMVYX			1,061,335.31	924,861.54
1PMEGX			2,074,154.15	1,771,755.27
1FXAIX			13,088,343.04	18,051,201.90
1JDVWX			1,923,616.58	2,050,821.03
1MLAIX			2,336,322.55	2,353,705.41
1FTIAX			553,560.51	557,743.07
1FTKFX			3,133,573.85	3,204,904.51
1PONAX			2,104,849.64	2,104,005.73
1VAIPX			1,492,716.03	1,449,024.43
1VMFXX			1,111,902.81	1,111,909.53
			148,711,153.52	**174,681,148.91**
* PARTICIPANT LOANS	VARIOUS	4.250-9.500	867,440.61	867,419.87
FORFEITURES			391,285.56	391,285.56

Attachment to Form 5500, Schedule H, Part 4, Item I
EIN # 381359265

*Indicates Party-in-interest

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE

LEGEND

INVESTMENT OPTION:

1TFRRX	T Rowe Price Target 2005 I	1TORFX	T Rowe Price Target 2010 I
1TTRTX	T Rowe Price Target 2015 I	1TTURX	T Rowe Price Target 2020 I
1TRVVX	T Rowe Price Target 2025 I	1TWRRX	T Rowe Price Target 2030 I
1TPGPX	T Rowe Price Target 2035 I	1TRXRX	T Rowe Price Target 2040 I
1TRFWX	T Rowe Price Target 2045 I	1TOORX	T Rowe Price Target 2050 I
1TRPPX	T Rowe Price Target 2055 I	1TTOIX	T Rowe Price Target 2060 I
1RPFDX	T. Rowe Price Target 2065 I	1RERGX	American Funds Eupac R6
1VWILX	Vanguard International Growth Adm	1ABSAX	American Beacon Small Cp Val A
1TQAIX	T. Rowe Price Integrated US Sm Gr Eq I	1FSMAX	Fidelity Extended Market Index
1JMVYX	JPMorgan Mid Cap Value R6	1PMEGX	T. Rowe Price Instl Mid-Cap Equity Gr
1FXAIX	Fidelity 500 Index	1JDVWX	JHancock Disciplined Value R6
1MLAIX	NYLI Winslow Large Cap Growth I	1FTIAX	Federated Hermes Short-Term Income A
1FTKFX	Fidelity Total Bond K6	1PONAX	PIMCO Income A
1VAIPX	Vanguard Inflation-Protected Secs Adm	1VMFXX	Vanguard Federal Money Market Inv

COST OF ASSETS: The original cost of the assets in each investment option as of the last day of the plan year
CURRENT VALUE: The value of all assets in each investment option as of the last day of the plan year

*Indicates Party-in-interest

Date Range Requested: **01/01/2025 - 12/31/2025** **Data Extracted:** **02/02/2026**

Plan Information

Vendor System	Plan ID	Plan Name	Plan Number	Employer Identification Number (EIN)	Plan Type	Full Service	Plan Sponsor/ Employer Name	Plan Sponsor / Employer Address	Plan Sponsor / Plan Admin Phone
Lincoln - APS	CR21475	MARY FREE BED ORTHOTICS AND PROSTHETICS	000	00-0000000	403(b)	N	MARY FREE BED ORTHOTICS AND PROSTHETICS	ATTN RYAN PODVIN, 235 WEALTHY SE, GRAND RAPIDS, MI 49503-5299	
Lincoln - APS	CR34160	MARY FREE BED HOSPITAL RETIREMENT PLAN	000	38-1359265	403(b)	Y	MARY FREE BED HOSPITAL RETIREMENT PLAN	ATTN RYAN PODVIN, 235 WEALTHY ST SE, GRAND RAPIDS, MI 49503-5299	
Lincoln - APS	GP01015	MARY FREE BED HOSPITAL RETIREMENT PLAN	000	38-1359265	403(b)	Y	MARY FREE BED HOSPITAL RETIREMENT PLAN	ATTN RYAN PODVIN, 235 WEALTHY ST SE, GRAND RAPIDS, MI 49503-5299	

Plan Assets

(A)	(B) Identity of Issue	(C) Description of Investment	(D) Historical Cost	(E) Current Value
*	LINCOLN NAT'L LIFE - MULTIFUND	AB VPS SUSTAIN GLOBAL THEMATIC PORT		11,412.59
*	LINCOLN NAT'L LIFE - MULTIFUND	AMERICAN FUNDS GLOBAL GROWTH		7,312.81
*	LINCOLN NAT'L LIFE - MULTIFUND	AMERICAN FUNDS GROWTH		434,619.65
*	LINCOLN NAT'L LIFE - MULTIFUND	AMERICAN FUNDS GROWTH-INCOME		52,750.39
*	LINCOLN NAT'L LIFE - MULTIFUND	AMERICAN FUNDS INTERNATIONAL		70,238.66
*	LINCOLN NAT'L LIFE - MULTIFUND	FIDELITY VIP CONTRAFUND		109,584.85
*	LINCOLN NAT'L LIFE - MULTIFUND	FIDELITY VIP GROWTH		32,352.61
*	LINCOLN NAT'L LIFE - MULTIFUND	FIXED ACCOUNT		985,028.22

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.
PAD 1012-0880

* Indicates party-in-interest

*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP BARON GROWTH OPPORTUNITIES	64,053.48
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP BLACKROCK DIVIDEND VALUE MNGDVLTLTY	38,422.91
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP BLENDED LRG CAP GROWTH MNGD VOLTLTY	54,980.34
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP DIMENSIONAL U.S. CORE EQUITY 1	33,729.78
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP JPMORGAN RETIREMENT INCOME FUND	2,975.78
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE DIVERSIFIED INCOME	4,810.17
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE MID CAP VALUE FUND	40,894.22
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE SMID CAP CORE SERIES	217,288.61
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE SOCIAL AWARENESS	174,165.16
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE U.S. REIT FUND	10,389.04
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE VALUE SERIES	16,054.43
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MACQUARIE WEALTH BUILDER	3,460.18
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP MONDRIAN INTERNATIONAL VALUE	46,857.88
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP SSGA GLBL TACTICAL ALLOCTN MGD VLTY	10,109.13
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP SSGA S&P 500 INDEX	90,448.75
*	LINCOLN NAT'L LIFE - MULTIFUND	LVIP T. ROWE PRICE STRUCTURED MID-CAP GROWTH	47,018.96
*	LINCOLN NAT'L LIFE - MULTIFUND	MACQUARIE SMALL CAP VALUE	56,133.75
*	LINCOLN NAT'L LIFE - MULTIFUND	MFS UTILITIES	56,028.64
		Total	**2,671,120.99**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.
PAD 1012-0880

* Indicates party-in-interest

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2025

Fund Name	Share Balance 12/31/2025	Historical Cost	Price	Total Market Value
*FID FIDELITY FUND	323.328	$13,267.95	$112.31	$36,312.97
*FID PURITAN	960.556	$20,482.71	$26.05	$25,022.48
*FID SEL SEMICONDUCT	0.000		$43.24	$0.00
*FID SEL CONS STAPLES	53.292	$4,976.85	$83.22	$4,434.96
*FID GNMA	304.056	$3,363.38	$10.38	$3,156.10
*FID MAGELLAN	7,309.011	$79,018.69	$14.95	$109,269.71
*FID CONTRAFUND	2,652.300	$33,008.94	$24.30	$64,450.89
*FID EQUITY INC	860.890	$48,524.61	$83.61	$71,979.01
*FID GROWTH COMPANY	14,702.518	$265,535.77	$47.82	$703,074.41
*FID GROWTH & INC	1,010.330	$39,442.29	$68.25	$68,955.02
*FID INTERMED BOND	228.631	$2,411.54	$10.38	$2,373.19
*FID CAPITAL & INCOME	13,678.222	$135,191.27	$10.86	$148,545.49
*FID MORTGAGE SEC	817.407	$7,912.93	$10.02	$8,190.42
*FID SEL BIOTECH	728.145	$14,956.16	$25.13	$18,298.28
*FIDELITY GOVT INCOME	2,516.305	$23,204.08	$9.26	$23,300.98
*FID SEL ENERGY	97.770	$3,578.34	$61.56	$6,018.72
*FID SEL LEISURE	505.074	$8,184.18	$17.76	$8,970.11
*FID SEL TECHNOLOGY	254.050	$10,036.23	$41.43	$10,525.29
*FID SEL DEFENSE	318.528	$3,814.46	$25.87	$8,240.32
*FID OTC PORTFOLIO	13,185.213	$141,246.32	$24.28	$320,136.97
*FID EUROPE	605.254	$22,949.95	$46.64	$28,229.05
*FID PACIFIC BASIN	414.109	$13,448.43	$38.74	$16,042.58
*FID REAL ESTATE INVS	0.000		$37.82	$0.00
*FID BALANCED	6,588.130	$165,195.89	$32.13	$211,676.62
*FID INTL DISCOVERY	362.837	$16,889.62	$57.14	$20,732.51
*FID CANADA	93.509	$4,548.63	$78.18	$7,310.53
*FID BLUE CHIP GR	1,469.107	$119,926.92	$267.04	$392,310.33
*FID ASSET MGR 50%	16,360.967	$282,559.30	$21.82	$356,996.30
*FID DISCIPLND EQTY	667.358	$23,609.70	$72.39	$48,310.05
*FID LOW PRICED STK	2,993.106	$130,111.15	$41.23	$123,405.76
*FID EQ DIV INCOME	1,211.925	$31,555.06	$29.71	$36,006.29
*FID ASSET MGR 70%	17,180.896	$329,098.91	$30.09	$516,973.16
*FID EMERGING MKTS	93.442	$3,610.62	$49.87	$4,659.95
*FID GROWTH STRAT	266.341	$17,149.93	$68.28	$18,185.76
*FID DIVERSIFD INTL	114.562	$4,752.35	$48.63	$5,571.15
*FID DIVIDEND GR	6,171.463	$194,206.28	$42.56	$262,657.47
*FID MID CAP STOCK	6,088.625	$201,197.93	$46.46	$282,877.52

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2025

Fund Name	Share Balance 12/31/2025	Historical Cost	Price	Total Market Value
*FID SMALL CAP STOCK	640.683	$11,601.99	$18.45	$11,820.60
*FID SM CAP DISCOVERY	490.528	$12,261.51	$23.29	$11,424.40
*FID INTM GOVT INCOME	548.599	$5,297.82	$9.93	$5,447.59
*FID SEL HTH CARE SVC	259.500	$20,012.08	$102.61	$26,627.30
*FID NATURAL RES	0.000		$52.51	$0.00
*FID SEL PHARMACEUTCL	453.213	$7,748.39	$30.91	$14,008.81
*FID LTD TERM GOVT	559.441	$5,345.93	$9.77	$5,465.74
*FID STKSEL LGCAP VAL	1,742.416	$47,538.08	$29.17	$50,826.27
*FID TOTAL BOND	562.664	$5,887.56	$9.67	$5,440.96
*FID SMALL CAP VALUE	563.405	$11,103.14	$20.00	$11,268.10
*FID CORPORATE BOND	2,274.750	$23,694.81	$10.77	$24,499.06
*FID US BOND IDX	1,091.204	$12,105.05	$10.56	$11,523.11
*FID 500 INDEX	1,126.014	$182,641.57	$237.72	$267,676.05
*FID MID CAP IDX	281.228	$8,724.76	$36.93	$10,385.75
*FID GLOBAL EQ INCOME	222.311	$3,851.43	$24.87	$5,528.87
*FID FREEDOM 2020 K	2,079.680	$29,164.04	$15.33	$31,881.49
*FID FREEDOM 2030 K	17,035.521	$280,880.62	$19.53	$332,703.73
*FID FREEDOM 2035 K	436.927	$6,300.40	$17.72	$7,742.35
*FID FREEDOM 2040 K	11,900.233	$124,048.12	$13.38	$159,225.12
*FID LT TR BD IDX	4,343.225	$47,689.24	$9.29	$40,348.56
*FID STRATEGIC INCOME	450.554	$5,509.68	$12.09	$5,447.20
*OUTSTANDING LOAN BALANCE				$0.00
			NET ASSETS 12/31/2025:	$5,012,491.41

Assets are presented at fair value with the exception to fully benefit responsive investment contracts which are presented at contract value as in previous years. See Chapter 7 of the Fidelity Auditor's Guide for financial statement presentation and disclosure information.

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2025

Fund Name	Share Balance 12/31/2025	Historical Cost	Price	Total Market Value
*FID VALUE STRAT	1,682.940	$62,376.53	$54.84	$92,292.43
*FID MAGELLAN	24,550.341	$260,632.48	$14.95	$367,027.60
*FID CONTRAFUND	176.435	$1,988.36	$24.30	$4,287.37
*FID GROWTH COMPANY	2,073.250	$42,590.78	$47.82	$99,142.82
*FID VALUE	6,749.569	$68,672.47	$13.78	$93,009.06
*FID SEL BIOTECH	406.640	$7,833.11	$25.13	$10,218.86
*FID REAL ESTATE INVS	46.429	$1,596.93	$37.82	$1,755.94
*FID FOCUSED STOCK	453.945	$11,519.57	$38.38	$17,422.41
*FID MID CAP STOCK	2,299.224	$77,279.05	$46.46	$106,821.95
*FID SEL MED TECH&DV	78.113	$3,246.58	$60.25	$4,706.31
*FID INTL SMALL CAP	58.140	$1,445.07	$36.82	$2,140.71
*OUTSTANDING LOAN BALANCE				$0.00
			NET ASSETS 12/31/2025:	$798,825.46

Assets are presented at fair value with the exception to fully benefit responsive investment contracts which are presented at contract value as in previous years. See Chapter 7 of the Fidelity Auditor's Guide for financial statement presentation and disclosure information.

	Values										
	BEGINNING VALUE	CONTRIBUTIONS	TRANSFERS/ROLLOVERS	FUND TRANSFERS	WITHDRAWALS	LOAN REPAYMENTS	LOAN WITHDRAWALS	FEES	VALUE ADJUSTMENTS	GAIN/LOSS	ENDING VALUE
AMERICAN FUNDS GROWTH FUND	$4,937.72	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$918.62	$5,856.34
BAILLIE GIFFORD INTERNATIONAL STOCK PORTFOLIO	$9,598.46	$0.00	$0.00	($85.80)	$0.00	$57.83	$0.00	$0.00	$0.00	$1,708.71	$11,279.20
BLACKROCK BOND INCOME PORTFOLIO	$5,671.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$374.91	$6,046.32
BRIGHTHOUSE/WELLINGTON BALANCED PORTFOLIO	$281.73	$0.00	$0.00	$0.00	($15.29)	$0.00	$0.00	$0.00	$0.00	$30.14	$296.58
BRIGHTHOUSE/WELLINGTON CORE EQUITY OPPORTUNITIES PORTFOLIO	$444.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$31.65	$475.66
BRIGHTHOUSE/WELLINGTON LARGE CAP RESEARCH PORTFOLIO	$82,673.41	$0.00	$0.00	$35.77	($12.90)	$86.72	$0.00	$0.00	$0.00	$12,117.04	$94,900.04
FRONTIER MID CAP GROWTH PORTFOLIO	$23,357.26	$0.00	$0.00	$35.81	($6.34)	$86.75	$0.00	$0.00	$0.00	$834.80	$24,308.28
GUARANTEED FIXED ACCOUNT	$83,107.63	$0.00	$0.00	$0.00	($0.74)	$0.00	$0.00	($40.00)	$0.00	$2,819.97	$85,886.86
INVESCO GLOBAL EQUITY PORTFOLIO	$46,357.63	$0.00	$0.00	$23.88	$0.00	$57.82	$0.00	$0.00	$0.00	$6,565.75	$53,005.08
JENNISON GROWTH PORTFOLIO	$2,412.21	$0.00	$0.00	($79.40)	$0.00	$0.00	$0.00	$0.00	$0.00	$337.58	$2,670.39
LOAN COLLATERAL	$7,203.16	$0.00	$0.00	($817.05)	$0.00	$0.00	$0.00	$0.00	$0.00	$238.95	$6,625.06
METLIFE AGGREGATE BOND INDEX PORTFOLIO	$4,789.39	$0.00	$0.00	$21.57	$0.00	$0.00	$0.00	$0.00	$0.00	$274.36	$5,085.32
METLIFE MID CAP STOCK INDEX PORTFOLIO	$12,928.51	$0.00	$0.00	$928.15	$0.00	$0.00	$0.00	$0.00	$0.00	$843.06	$14,699.72
METLIFE MSCI EAFE INDEX PORTFOLIO	$25,061.02	$0.00	$0.00	($1,925.48)	$0.00	$0.00	$0.00	$0.00	$0.00	$7,000.90	$30,136.44
METLIFE RUSSELL 2000 INDEX PORTFOLIO	$12,470.35	$0.00	$0.00	$295.40	$0.00	$0.00	$0.00	$0.00	$0.00	$1,548.59	$14,314.34
METLIFE STOCK INDEX PORTFOLIO	$137,247.65	$0.00	$0.00	$728.11	($15.47)	$115.66	$0.00	$0.00	$0.00	$22,801.82	$160,877.77
MFS VALUE PORTFOLIO	$140.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.18	$157.72
MFS VALUE PORTFOLIO CLASS E	$2,436.44	$0.00	$0.00	($50.38)	$0.00	$0.00	$0.00	$0.00	$0.00	$293.86	$2,679.92
MORGAN STANLEY DISCOVERY PORTFOLIO	$21,517.38	$0.00	$0.00	($76.14)	($5.86)	$86.78	$0.00	$0.00	$0.00	$2,518.72	$24,040.88
NEUBERGER BERMAN GENESIS PORTFOLIO	$2,203.01	$0.00	$0.00	$257.80	$0.00	$0.00	$0.00	$0.00	$0.00	($116.15)	$2,344.66
T. ROWE PRICE SMALL CAP GROWTH PORTFOLIO	$35,968.91	$0.00	$0.00	$35.80	($9.82)	$86.75	$0.00	$0.00	$0.00	$3,170.22	$39,251.86
VICTORY SYCAMORE MID CAP VALUE PORTFOLIO	$1,715.69	$0.00	$0.00	$93.65	$0.00	$0.00	$0.00	$0.00	$0.00	$31.35	$1,840.69
Grand Total	$522,523.52	$0.00	$0.00	($578.31)	($66.42)	$578.31	$0.00	($40.00)	$0.00	$64,362.03	$586,779.13

* Indicates party-in-interest

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS HELD AT END OF YEAR

See complete related attachment under the audited financial statements attachment package.

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.)
- ☒ 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
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 04/01/1987

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)
MARY FREE BED REHABILITATION HOSPITAL

235 WEALTHY SE

GRAND RAPIDS MI 49503-5299

2b Employer Identification Number (EIN) 38-1359265

2c Plan Sponsor's telephone number 616-840-8361

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	Randi Bowers-Payne	9/24/26	RANDI BOWERS PAYNE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Randi Bowers-Payne	9/24/26	RANDI BOWERS PAYNE
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2025)
v. 250312

518401 12-22-25

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	3,332
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)	2,361
a (2) Total number of active participants at the end of the plan year	6a(2)	2,663
b Retired or separated participants receiving benefits	6b	347
c Other retired or separated participants entitled to future benefits	6c	559
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	3,569
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	3
f Total. Add lines 6d and 6e	6f	3,572
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)	3,294
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	3,424
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	411
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:
2F 2G 2L 2M 2T

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)	9b Plan benefit arrangement (check all that apply)
(1) ☒ Insurance	(1) ☒ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts	(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☒ Trust	(3) ☒ Trust
(4) ☐ General assets of the sponsor	(4) ☐ General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

(1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information - Small Plan)
(3) ☒ **A** (Insurance Information) - Number Attached 6
(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 _____