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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/01/1988

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)
WASHINGTON REGIONAL MEDICAL CENTER

3215 N. NORTH HILLS BLVD
FAYETTEVILLE, AR 72703

2b Employer Identification Number (EIN) 71-0664687

2c Plan Sponsor's telephone number 479-463-1000

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.	10/08/2026	MOLLY ONSTOTT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/08/2026	MOLLY ONSTOTT
	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**	2356
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)**	2350
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	2465
b	Retired or separated participants receiving benefits	**6b**	9
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2474
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
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)**	
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)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4E 4F 4H 4L 4Q

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)** [ ] **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)** [ ] **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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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
STANDARD 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
93-0242990	69019	755559	4145	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
58009	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

LOCKTON COMPANIES LLC
65 MEMORIAL RD
STE C100 RUTHERFORD BUILDING
WEST HARTFORD, CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
51212	0		3

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

LOCKTON COMPANIES LLC
8110 E UNION
SUITE 700
DENVER, CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6797	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 ▶

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

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** [X] 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)**	474272		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	2050		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	476322
b Benefit charges (1) Claims paid	**9b(1)**	413731		
(2) Increase (decrease) in claim reserves	**9b(2)**	259546		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	673277
(4) Claims charged			**9b(4)**	673277
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	58009		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	106062		
(E) Taxes	**9c(1)(E)**	11908		
(F) Charges for risks or other contingencies	**9c(1)(F)**	50361		
(G) Other retention charges	**9c(1)(G)**	0		
(H) Total retention			**9c(1)(H)**	226340
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	0
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
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**	0

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 [X] 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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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
COMBINED INSURANCE

(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
36-2136262	62146	LBT	262	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
5255	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

EXPLAIN MY BENEFITS
2461 WEST STATE ROAD 426
SUITE 2021
OVIEDO, FL 32765

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3680	0		3

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

STEPHENS INSURANCE LLC
3425 NORTH FUTRALL DRIVE
SUITE 201
FAYETTEVILLE, AR 72703

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1333	0		3

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

LOCKTON COMPANIES LLC

444 W. 47TH ST
SUITE 900
KANSAS CITY, MO 64112

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
242	0		3

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

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

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

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

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

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

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

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

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**	
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 ▶

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

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** [X] 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** [X] Other (specify) ▶ LONG TERM CARE

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	125772
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 [X] 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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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	028419	7406	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
29445	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

LOCKTON COMPANIES, LLC
P.O. BOX 843844
KANSAS CITY, MO 64184

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
29445	0		3

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

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

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

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

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

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

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

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

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

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

(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**	
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 ▶

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

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** [X] 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**	293305
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 [X] 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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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
RELIASTAR 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
41-0451140	67105	723983	1753	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
93271	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

LOCKTON COMPANIES LLC
444 WEST 47TH ST STE 900
KANSAS CITY, MO 64112-1906

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
93271	0		3

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

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

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

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

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

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

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

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

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

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

(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**	
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 ▶

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

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) ▶ ACCIDENT, CRITICAL ILLNESS, HOSPITAL CONFINEMENT

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**	446423
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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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
STANDARD 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
93-0242990	69019	755559	922	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
33194	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

LOCKTON COMPANIES LLC
65 MEMORIAL RD
STE C100 RUTHERFORD BUILDING
WEST HARTFORD, CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
28151	0		3

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

LOCKTON COMPANIES LLC
8110 E UNION
SUITE 700
DENVER, CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5043	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 ▶

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

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** [X] 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)**	372750		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	1972		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	374722
b Benefit charges (1) Claims paid	**9b(1)**	113741		
(2) Increase (decrease) in claim reserves	**9b(2)**	4970		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	118711
(4) Claims charged			**9b(4)**	118711
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	33194		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	66834		
(E) Taxes	**9c(1)(E)**	9368		
(F) Charges for risks or other contingencies	**9c(1)(F)**	26230		
(G) Other retention charges	**9c(1)(G)**	120384		
(H) Total retention			**9c(1)(H)**	256010
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	0
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
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**	0

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 [X] 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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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
STANDARD 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
93-0242990	69019	755559	3073	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
73874	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

LOCKTON COMPANIES LLC
65 MEMORIAL RD
STE C100 RUTHERFORD BUILDING
WEST HARTFORD, CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
64521	0		3

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

LOCKTON COMPANIES LLC
8110 E UNION
SUITE 700
DENVER, CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9353	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 ▶

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

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** [X] 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)**	587544		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	-2490		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	585054
b Benefit charges (1) Claims paid	**9b(1)**	559000		
(2) Increase (decrease) in claim reserves	**9b(2)**	453522		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	1012522
(4) Claims charged			**9b(4)**	1012522
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	73874		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	71920		
(E) Taxes	**9c(1)(E)**	14626		
(F) Charges for risks or other contingencies	**9c(1)(F)**	40134		
(G) Other retention charges	**9c(1)(G)**	0		
(H) Total retention			**9c(1)(H)**	200554
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	36360
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
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 [X] 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 WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN	**B** Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON REGIONAL MEDICAL CENTER	**D** Employer Identification Number (EIN) 71-0664687

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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(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)

BLUEADVANTAGE ADMINISTRATIONS OF ARKANSAS
PO BOX 3743
LITTLE ROCK, AR 72203

71-0226428

(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?
12 13 50	NONE	1173189	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

METROPOLITAN LIFE INSURANCE COMPANY

13-5581829

(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?
12 13 50	NONE	141381	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CAPITAL RX

35-2612946

(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?
12 13 50	NONE	76634	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EXPRESS SCRIPTS

43-1420563

(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?
12 13 50	NONE	34814	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE H (Form 5500)

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
WASHINGTON REGIONAL MEDICAL SYSTEM WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WASHINGTON REGIONAL MEDICAL CENTER

D Employer Identification Number (EIN)
71-0664687

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)	1582460	1686529
(2) Participant contributions	1b(2)	613329	660321
(3) Other	1b(3)	2585010	1718400
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	114031	3204444
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(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	4894830	7269694
Liabilities			
1g Benefit claims payable	1g	2001543	2363392
1h Operating payables	1h	0	
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	2001543	2363392
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	2893287	4906302

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)	22081751	
(B) Participants	2a(1)(B)	8679748	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		30761499
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	95455	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		95455
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(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)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		30856954
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	27266307	
(2) To insurance carriers for the provision of benefits	2e(2)	60120	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		27326427
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1517512	
(3) Recordkeeping fees	2i(3)		
(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)		1517512
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		28843939
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		2013015
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) [X] 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) [X] 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: FORVIS MAZARS, LLP **(2)** EIN: 44-0160260

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		3000000
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**			
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**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] 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 _____.

Washington Regional Medical System Welfare Benefit Plan

EIN 71-0664687 PN 501

Independent Auditor's Report, Financial Statements, and Supplemental Schedules

December 31, 2025 and 2024

Washington Regional Medical System Welfare Benefit Plan
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December 31, 2025 and 2024

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Independent Auditor's Report

Employee Benefits Committee, Board of Directors,
and Plan Administrator
Washington Regional Medical System Welfare Benefit Plan
Fayetteville, Arkansas

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

We have performed audits of the financial statements of Washington Regional Medical System Welfare Benefit Plan (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 net assets available for benefits and plan's benefit obligations as of December 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and changes in plan's benefit obligations 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 the Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from a qualified institution as of December 31, 2025 and 2024, and for the years then ended, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Opinion

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

- The amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- The information in the accompanying financial statements related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the "Auditor's Responsibilities for the Audit of the Financial Statements" section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

In performing an audit in accordance with GAAS, we:

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

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

Our audits did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.

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

Other Matter – Supplemental Schedules Required by ERISA

The supplemental schedules listed in the table of contents are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, other than the information agreed to or derived from the certified investment information, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion:

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

Forvis Mazars, LLP

Rogers, Arkansas
October 8, 2026

Federal Employer Identification Number: 44-0160260

Washington Regional Medical System Welfare Benefit Plan
Statements of Net Assets Available for Benefits
December 31, 2025 and 2024

	2025	2024
ASSETS		
Investments, at fair value	$ 3,204,444	$ 114,031
Receivables		
Employer contribution	1,686,529	1,582,460
Participant contributions	660,321	613,329
Pharmacy rebate	1,709,549	2,580,529
COBRA receivable	8,851	4,481
	4,065,250	4,780,799
Net Assets Available for Benefits	$ 7,269,694	$ 4,894,830

Washington Regional Medical System Welfare Benefit Plan
Statements of Changes in Net Assets Available for Benefits
Years Ended December 31, 2025 and 2024

	2025	2024
Additions		
Investment Income		
Interest	$ 95,455	$ 31,914
Net Investment Income	95,455	31,914
Contributions		
Employer	22,081,751	19,287,580
Participants	8,679,748	7,645,094
Total Contributions	30,761,499	26,932,674
Total Additions	30,856,954	26,964,588
Deductions		
Benefits paid to participants, net	26,904,458	23,543,202
Insurance premiums and incentive program expenses	60,120	176,756
Administrative expenses	1,517,512	1,453,517
Total Deductions	28,482,090	25,173,475
Net Increase	2,374,864	1,791,113
Net Assets Available for Benefits, Beginning of Year	4,894,830	3,103,717
Net Assets Available for Benefits, End of Year	$ 7,269,694	$ 4,894,830

Washington Regional Medical System Welfare Benefit Plan
Statements of Plan's Benefit Obligations
December 31, 2025 and 2024

	2025	2024
Amounts Currently Payable to or for Participants, Beneficiaries, and Dependents		
Health and dental claims payable	$ 672,841	$ 385,774
Other Obligations for Current Benefit Coverage, at Present Value of Estimated Amounts		
Claims incurred but not reported	1,690,551	1,615,769
Plan's Total Benefit Obligations	$ 2,363,392	$ 2,001,543

Washington Regional Medical System Welfare Benefit Plan
Statements of Changes in Plan's Benefit Obligations
Years Ended December 31, 2025 and 2024

	2025	2024
Amounts Currently Payable to or for Participants, Beneficiaries, and Dependents		
Balance at beginning of year	$ 385,774	$ 624,640
Claims reported and approved for payment	27,191,525	23,304,336
Claims paid	(26,904,458)	(23,543,202)
Balance at end of year	672,841	385,774
Other Obligations for Current Benefit Coverage, at Present Value of Estimated Amounts		
Balance at beginning of year	1,615,769	1,682,689
Net change during year		
Claims incurred but not reported	74,782	(66,920)
Balance at end of year	1,690,551	1,615,769
Plan's Total Benefit Obligations, End of Year	$ 2,363,392	$ 2,001,543

Note 1. Description of the Plan

General

The following description of Washington Regional Medical System Welfare Benefit Plan (Plan) provides only general information about the Plan's provisions. Participants should refer to the plan document for a more complete description of the Plan's provisions, which is available from the plan administrator.

The Plan provides health and dental benefits covering all employees of Washington Regional Medical System (System) and covered dependents. Additionally, effective December 13, 2022, active employees who retire from active service and accept the 2023 Voluntary Early Retirement Incentive Plan will receive medical benefits for a period of three years or to age 65, whichever comes first, with continuing payment of premiums. Certain plan assets are held in a trust. The Plan is subject to the provisions of the *Employee Retirement Income Security Act of 1974* (ERISA), as amended.

Self-Insured Benefits

The Plan provides self-insured health benefits (medical, hospital, surgical, major medical, dental, and pharmaceutical) to eligible participants and to their beneficiaries and covered dependents. The Plan also provides benefits to certain terminated employees under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA). The claims for self-insured benefits are processed by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the general trust of the Plan.

During 2025 and 2024, Blue Advantage Administrators of Arkansas (Blue Advantage) and MetLife, Inc. Dental processed health and dental claims, respectively, of active and COBRA participants, dependents, and beneficiaries. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan.

The Plan utilizes a pharmacy benefit manager (PBM), which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs.

Stop-Loss Coverage

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims).

Premiums for stop-loss insurance are included in premium payments in the statements of changes in net assets available for benefits. There were no stop-loss refunds for 2025 or 2024.

Contributions

The System contributes an amount as determined annually by the board of directors. Employees and COBRA participants contribute specified amounts, determined periodically by the System, to maintain coverage for themselves and eligible dependents.

Plan Termination

Although it has not expressed any intent to do so, the System has the right under the Plan to modify the benefits provided to, and contributions required of, participants, to discontinue its contributions at any time, and to terminate the Plan, subject to the provisions of ERISA. In the event of termination of the Plan, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants. No assets of the Plan may revert to the System or be used for purposes other than for the exclusive benefit of the Plan's participants.

Note 2. Summary of Significant Accounting Policies

Basis of Accounting

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

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, health claims incurred but not reported (IBNR), claims payable, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Payment of Benefits

Premiums paid by the Plan are recorded as premium payments in the statements of changes in net assets available for benefits.

Claim payments are recorded when paid by the third-party claims processor. Amounts due to claims processors that have yet to be reimbursed by the Plan, if any, are recorded as payable to claims administrators in the statements of net assets available for benefits. The third-party claims processor processes health, disability, and death claims to active participants, dependents, and beneficiaries, but the responsibility for payments to participants and providers is retained by the Plan. These payments are recorded as benefits paid to participants in the statements of changes in net assets available for benefits.

Pharmacy Rebates

Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against benefits paid. Pharmacy rebates totaling $3,493,048 and $5,493,691 have been netted with benefits paid in the statements of changes in net assets available for benefits for the years ended December 31, 2025 and 2024, respectively.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value, which equals the cost of the investment; therefore, there is no gain or loss recorded on investments.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

Plan Benefit Obligations

Plan obligations for health and dental claims IBNR are estimated based upon historical claims experience and actual claims reported subsequent to the Plan's year-end. Additional accruals are included for the estimated ultimate cost of future claims only if such claims are covered as of the Plan's fiscal year-end and the Plan is obligated to pay for the care regardless of continued participation in the Plan.

Administrative Expenses

Administrative expenses may be paid by the System or the Plan, at the System's discretion.

Note 3. Certification of Plan Trustee

The plan administrator has elected the method of annual reporting compliance permitted by 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. Accordingly, The Bank of Fayetteville, a qualified institution, has certified the following investment information included in the financial statements and ERISA-required supplemental schedules is complete and accurate to the best of their knowledge:

- Investments as shown in the statements of net assets available for benefits and related disclosures as of December 31, 2025 and 2024
- Interest income as shown in the statements of changes in net assets available for benefits for the years ended December 31, 2025 and 2024
- Investment information included in the schedule of assets (held at end of year) as of December 31, 2025 and schedule of reportable transactions for the year ended December 31, 2025

The Plan's independent auditors did not perform auditing procedures with respect to this certified investment information, except for comparing such certified investment information to the related information included in the financial statements and ERISA-required supplemental schedules.

Note 4. Related-Party and Party-in-Interest Transactions

Party-in-interest transactions include those with fiduciaries or employees of the Plan, any person who provides services to the Plan, an employer whose employees are covered by the Plan, an employee organization whose members are covered by the Plan, a person who owns 50% or more of such an employer or employee association, or relatives of such persons.

The Plan's investments are held by the trustee. The Plan has a number of service providers. Such providers are parties in interest under ERISA. Funds in the amount of $1,577,632 and $1,688,253 for the years ended December 31, 2025 and 2024, respectively, were paid by the Plan to The Bank of Fayetteville, Blue Advantage, Delta Dental, MetLife, Inc. Dental, Express Scripts, Aon Consulting, USAble Partners, US Corporate Wellness, and HealthScope Benefits, Inc. for premiums, incentive program expenses, and administrative expenses. The Plan incurs expenses related to general administrative, record-keeping, and certain accounting and auditing fees, which are paid by the System.

Note 5. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Form 5500 at December 31:

	2025	2024
Net assets available for benefits per the financial statements	$ 7,269,694	$ 4,894,830
Benefit obligations currently payable (health claims, death, and disability benefits)	(2,363,392)	(2,001,543)
Net assets available for benefits per Form 5500	$ 4,906,302	$ 2,893,287

The following is a reconciliation of benefits paid to participants per the financial statements to Form 5500 for the years ended December 31:

	2025	2024
Benefits paid to participants per the financial statements	$ 26,904,458	$ 23,543,202
Add amounts payable at end of year	2,363,392	2,001,543
Less amounts payable at beginning of year	(2,001,543)	(2,307,329)
Benefits paid to participants per Form 5500	$ 27,266,307	$ 23,237,416

Amounts currently payable to or for participants, dependents, and beneficiaries are recorded on Form 5500 for benefit claims that have been processed and approved for payment and claims IBNR prior to December 31 but not yet paid as of that date.

Note 6. Disclosures About Fair Value of Plan Assets and Liabilities

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. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs that are supported by little or no market activity and significant to the fair value of the assets or liabilities

Recurring Measurements

The following table presents the fair value measurements of assets recognized in the statements of net assets available for benefits measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31. Investments at December 31, 2025 consist of interest-bearing cash, which is recorded at cost, which approximates fair value and is not disclosed in the fair value leveling.

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2024				
Federated Treasury Obligation Fund #398	$ 114,031	$ 114,031	$ -	$ -

The following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the statements of net assets available for benefits, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended December 31, 2025 and 2024. The Plan had no liabilities measured at fair value on a recurring basis. In addition, the Plan had no assets or liabilities measured at fair value on a nonrecurring basis.

Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy.

Note 7. Risks and Uncertainties

The Plan invests in various investment securities and maintains deposits in certain financial institutions that are exposed to various risks such as interest rate, market, custodial, 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 assets will occur in the near term and that such changes could materially affect the participants' account balances and the amounts reported in the statements of net assets available for benefits.

Note 8. Tax Status

No request for tax-exempt status has been filed with the IRS. However, the plan administrator believes that the Plan and related trust are currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Note 9. Subsequent Events

Subsequent events have been evaluated through October 8, 2026, which is the date the financial statements were available to be issued.

Supplemental Schedules

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4i – Schedule of Assets (Held at End of Year)
December 31, 2025

Identity of Issue	Description of Investment	Cost	Current Value
Bank of Fayetteville Money Market Fund	Money Market Fund, 3,204,443.92 shares	$ 3,204,444	$ 3,204,444

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
		Category (i) – Individual Transactions in Excess of 5% of Plan Assets					
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 318,239 shares	$ 318,239	$ -	$ -	$ 318,239	$ 318,239	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 454,360 shares	$ 454,360	$ -	$ -	$ 454,360	$ 454,360	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 475,104 shares	$ 475,104	$ -	$ -	$ 475,104	$ 475,104	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 848,350 shares	$ 848,350	$ -	$ -	$ 848,350	$ 848,350	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,014,298 shares	$ 1,014,298	$ -	$ -	$ 1,014,298	$ 1,014,298	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,041,349 shares	$ 1,041,349	$ -	$ -	$ 1,041,349	$ 1,041,349	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,044,299 shares	$ 1,044,299	$ -	$ -	$ 1,044,299	$ 1,044,299	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,051,584 shares	$ 1,051,584	$ -	$ -	$ 1,051,584	$ 1,051,584	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,053,898 shares	$ 1,053,898	$ -	$ -	$ 1,053,898	$ 1,053,898	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,059,626 shares	$ 1,059,626	$ -	$ -	$ 1,059,626	$ 1,059,626	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,066,560 shares	$ 1,066,560	$ -	$ -	$ 1,066,560	$ 1,066,560	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,071,861 shares	$ 1,071,861	$ -	$ -	$ 1,071,861	$ 1,071,861	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,072,271 shares	$ 1,072,271	$ -	$ -	$ 1,072,271	$ 1,072,271	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,171,308 shares	$ 1,171,308	$ -	$ -	$ 1,171,308	$ 1,171,308	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,175,898 shares	$ 1,175,898	$ -	$ -	$ 1,175,898	$ 1,175,898	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,176,362 shares	$ 1,176,362	$ -	$ -	$ 1,176,362	$ 1,176,362	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,177,231 shares	$ 1,177,231	$ -	$ -	$ 1,177,231	$ 1,177,231	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,177,634 shares	$ 1,177,634	$ -	$ -	$ 1,177,634	$ 1,177,634	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,181,553 shares	$ 1,181,553	$ -	$ -	$ 1,181,553	$ 1,181,553	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,182,113 shares	$ 1,182,113	$ -	$ -	$ 1,182,113	$ 1,182,113	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,185,495 shares	$ 1,185,495	$ -	$ -	$ 1,185,495	$ 1,185,495	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,185,973 shares	$ 1,185,973	$ -	$ -	$ 1,185,973	$ 1,185,973	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,186,682 shares	$ 1,186,682	$ -	$ -	$ 1,186,682	$ 1,186,682	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,187,652 shares	$ 1,187,652	$ -	$ -	$ 1,187,652	$ 1,187,652	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,191,305 shares	$ 1,191,305	$ -	$ -	$ 1,191,305	$ 1,191,305	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,191,554 shares	$ 1,191,554	$ -	$ -	$ 1,191,554	$ 1,191,554	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,192,574 shares	$ 1,192,574	$ -	$ -	$ 1,192,574	$ 1,192,574	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,202,049 shares	$ 1,202,049	$ -	$ -	$ 1,202,049	$ 1,202,049	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,202,461 shares	$ 1,202,461	$ -	$ -	$ 1,202,461	$ 1,202,461	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,204,879 shares	$ 1,204,879	$ -	$ -	$ 1,204,879	$ 1,204,879	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,207,234 shares	$ 1,207,234	$ -	$ -	$ 1,207,234	$ 1,207,234	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,216,296 shares	$ 1,216,296	$ -	$ -	$ 1,216,296	$ 1,216,296	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 247,177 shares	$ -	$ 247,177	$ -	$ 247,177	$ 247,177	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 250,062 shares	$ -	$ 250,062	$ -	$ 250,062	$ 250,062	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 263,481 shares	$ -	$ 263,481	$ -	$ 263,481	$ 263,481	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 264,761 shares	$ -	$ 264,761	$ -	$ 264,761	$ 264,761	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 268,355 shares	$ -	$ 268,355	$ -	$ 268,355	$ 268,355	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 271,187 shares	$ -	$ 271,187	$ -	$ 271,187	$ 271,187	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 273,978 shares	$ -	$ 273,978	$ -	$ 273,978	$ 273,978	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 275,400 shares	$ -	$ 275,400	$ -	$ 275,400	$ 275,400	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 279,283 shares	$ -	$ 279,283	$ -	$ 279,283	$ 279,283	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 291,421 shares	$ -	$ 291,421	$ -	$ 291,421	$ 291,421	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 292,447 shares	$ -	$ 292,447	$ -	$ 292,447	$ 292,447	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 292,616 shares	$ -	$ 292,616	$ -	$ 292,616	$ 292,616	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 296,283 shares	$ -	$ 296,283	$ -	$ 296,283	$ 296,283	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 299,754 shares	$ -	$ 299,754	$ -	$ 299,754	$ 299,754	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 313,386 shares	$ -	$ 313,386	$ -	$ 313,386	$ 313,386	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 321,714 shares	$ -	$ 321,714	$ -	$ 321,714	$ 321,714	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 324,829 shares	$ -	$ 324,829	$ -	$ 324,829	$ 324,829	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 328,047 shares	$ -	$ 328,047	$ -	$ 328,047	$ 328,047	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 348,936 shares	$ -	$ 348,936	$ -	$ 348,936	$ 348,936	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 350,435 shares	$ -	$ 350,435	$ -	$ 350,435	$ 350,435	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 355,513 shares	$ -	$ 355,513	$ -	$ 355,513	$ 355,513	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 359,682 shares	$ -	$ 359,682	$ -	$ 359,682	$ 359,682	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Bank of Fayetteville Money Market Sweep	Money Market Account, 363,939 shares	$ -	$ 363,939	$ -	$ 363,939	$ 363,939	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 368,112 shares	$ -	$ 368,112	$ -	$ 368,112	$ 368,112	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 375,500 shares	$ -	$ 375,500	$ -	$ 375,500	$ 375,500	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 376,643 shares	$ -	$ 376,643	$ -	$ 376,643	$ 376,643	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 380,556 shares	$ -	$ 380,556	$ -	$ 380,556	$ 380,556	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 381,754 shares	$ -	$ 381,754	$ -	$ 381,754	$ 381,754	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 383,561 shares	$ -	$ 383,561	$ -	$ 383,561	$ 383,561	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 384,233 shares	$ -	$ 384,233	$ -	$ 384,233	$ 384,233	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 388,164 shares	$ -	$ 388,164	$ -	$ 388,164	$ 388,164	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 388,306 shares	$ -	$ 388,306	$ -	$ 388,306	$ 388,306	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 400,174 shares	$ -	$ 400,174	$ -	$ 400,174	$ 400,174	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 401,085 shares	$ -	$ 401,085	$ -	$ 401,085	$ 401,085	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 410,800 shares	$ -	$ 410,800	$ -	$ 410,800	$ 410,800	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 411,810 shares	$ -	$ 411,810	$ -	$ 411,810	$ 411,810	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 413,391 shares	$ -	$ 413,391	$ -	$ 413,391	$ 413,391	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 414,242 shares	$ -	$ 414,242	$ -	$ 414,242	$ 414,242	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 417,363 shares	$ -	$ 417,363	$ -	$ 417,363	$ 417,363	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 418,474 shares	$ -	$ 418,474	$ -	$ 418,474	$ 418,474	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 418,904 shares	$ -	$ 418,904	$ -	$ 418,904	$ 418,904	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 420,494 shares	$ -	$ 420,494	$ -	$ 420,494	$ 420,494	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 423,442 shares	$ -	$ 423,442	$ -	$ 423,442	$ 423,442	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 435,093 shares	$ -	$ 435,093	$ -	$ 435,093	$ 435,093	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 441,046 shares	$ -	$ 441,046	$ -	$ 441,046	$ 441,046	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 451,556 shares	$ -	$ 451,556	$ -	$ 451,556	$ 451,556	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 467,862 shares	$ -	$ 467,862	$ -	$ 467,862	$ 467,862	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 497,150 shares	$ -	$ 497,150	$ -	$ 497,150	$ 497,150	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 504,166 shares	$ -	$ 504,166	$ -	$ 504,166	$ 504,166	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 515,313 shares	$ -	$ 515,313	$ -	$ 515,313	$ 515,313	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 552,384 shares	$ -	$ 552,384	$ -	$ 552,384	$ 552,384	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 558,868 shares	$ -	$ 558,868	$ -	$ 558,868	$ 558,868	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 561,306 shares	$ -	$ 561,306	$ -	$ 561,306	$ 561,306	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 576,126 shares	$ -	$ 576,126	$ -	$ 576,126	$ 576,126	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 585,378 shares	$ -	$ 585,378	$ -	$ 585,378	$ 585,378	$ -

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Bank of Fayetteville Money Market Sweep	Money Market Account, 611,617 shares	$ -	$ 611,617	$ -	$ 611,617	$ 611,617	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 657,992 shares	$ -	$ 657,992	$ -	$ 657,992	$ 657,992	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 670,617 shares	$ -	$ 670,617	$ -	$ 670,617	$ 670,617	$ -
	Category (iii) – Series of Transactions in Excess of 5% of Plan Assets						
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 22,920,932 shares	$ -	$ 22,920,932	$ -	$ 22,920,932	$ 22,920,932	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 27,156,318 shares	$ 27,156,318	$ -	$ -	$ 27,156,318	$ 27,156,318	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 9,045,767 shares	$ -	$ 9,045,767	$ -	$ 9,045,767	$ 9,045,767	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 7,813,777 shares	$ 7,813,777	$ -	$ -	$ 7,813,777	$ 7,813,777	$ -

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
Washington Regional Medical System Welfare Benefit Plan

1b Three-digit plan number (PN) ► 501

1c Effective date of plan 06/01/1988

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)

Washington Regional Medical Center

3215 N. North Hills Blvd

US Fayetteville AR 72703

2b Employer Identification Number (EIN) 71-0664687

2c Plan Sponsor's telephone number (479) 463-1000

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	Molly Onstott	10/9/2026	Molly Onstott
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [x] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN and 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**	2,356
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)**	2,350
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	2,465
b	Retired or separated participants receiving benefits	**6b**	9
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	2,474
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
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)**	
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)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4E 4F 4H 4L 4Q

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) [ ] **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) [ ] **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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ► 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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

Standard 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	Policy or contract year (g) To
93-0242990	69019	755559	4145	1/1/2025	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
58,009	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

Lockton Companies LLC
65 Memorial RD
STE C100 Rutherford Building
US West Hartford CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
51,212	0		3

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

Lockton Companies LLC
8110 E Union
Suite 700
US Denver CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
6,797	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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** [x] 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)	474,272		
(2) Increase (decrease) in amount due but unpaid	9a(2)	2,050		
(3) Increase (decrease) in unearned premium reserve	9a(3)	0		
(4) Earned ((1) + (2) - (3))			9a(4)	476,322
b Benefit charges (1) Claims paid	9b(1)	413,731		
(2) Increase (decrease) in claim reserves	9b(2)	259,546		
(3) Incurred claims (add (1) and (2))			9b(3)	673,277
(4) Claims charged			9b(4)	673,277
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)	58,009		
(B) Administrative service or other fees	9c(1)(B)	0		
(C) Other specific acquisition costs	9c(1)(C)	0		
(D) Other expenses	9c(1)(D)	106,062		
(E) Taxes	9c(1)(E)	11,908		
(F) Charges for risks or other contingencies	9c(1)(F)	50,361		
(G) Other retention charges	9c(1)(G)	0		
(H) Total retention			9c(1)(H)	226,340
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	0
(2) Claim reserves			9d(2)	0
(3) Other reserves			9d(3)	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	0
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	0

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 [x] 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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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

Combined Insurance

(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	Policy or contract year (g) To
36-2136262	62146	LBT	262	1/1/2025	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
5,255	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

Explain My Benefits
2461 West State Road 426
Suite 2021
US Oviedo FL 32765

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
3,680	0		3

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

Stephens Insurance LLC
3425 North Futrall Drive
Suite 201
US Fayetteville AR 72703

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
1,333	0		3

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

Lockton Companies LLC
444 W. 47th St
Suite 900
US Kansas City MO 64112

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
242	**0**		**3**

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

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

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

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

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

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

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

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

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**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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** [x] 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** [x] Other (specify) ► Long Term Care

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	125,772
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 [x] 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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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	Policy or contract year (g) To
13-5581829	65978	028419	7406	1/1/2025	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
29,445	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

Lockton Companies, LLC
P.O. Box 843844

US Kansas City MO 64184

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
29,445	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (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**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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	293,305
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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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

Reliastar 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	Policy or contract year (g) To
41-0451140	67105	723983	1753	1/1/2025	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
93,271	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

Lockton Companies LLC
444 West 47th St Ste 900

US Kansas City MO 64112-1906

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
93,271	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid (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**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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) ► **Accident, Critical Illness, Hospital Confinement**

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	446,423
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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ► 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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

Standard 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	Policy or contract year (g) To
93-0242990	69019	755559	922	1/1/2025	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
33,194	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

Lockton Companies LLC
65 Memorial RD
STE C100 Rutherford Building
US West Hartford CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
28,151	0		3

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

Lockton Companies LLC
8110 E Union
Suite 700
US Denver CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
5,043	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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** [x] 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)**	372,750		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	1,972		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned ((1) + (2) - (3))			**9a(4)**	374,722
b Benefit charges (1) Claims paid	**9b(1)**	113,741		
(2) Increase (decrease) in claim reserves	**9b(2)**	4,970		
(3) Incurred claims (add (1) and (2))			**9b(3)**	118,711
(4) Claims charged			**9b(4)**	118,711
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	33,194		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	66,834		
(E) Taxes	**9c(1)(E)**	9,368		
(F) Charges for risks or other contingencies	**9c(1)(F)**	26,230		
(G) Other retention charges	**9c(1)(G)**	120,384		
(H) Total retention			**9c(1)(H)**	256,010
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	0
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
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**	0

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 [x] 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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ► 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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

Standard 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
93-0242990	69019	755559	3073	1/1/2025	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
73,874	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

Lockton Companies LLC
65 Memorial Rd
STE C100 Rutherford Building
US West Hartford CT 06107

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
64,521	0		3

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

Lockton Companies LLC
8110 E Union
Suite 700
US Denver CO 80237

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
9,353	0		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	
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 on contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ►

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

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 organization(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)**	587,544		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	(2,490)		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned ((1) + (2) - (3))			**9a(4)**	585,054
b Benefit charges (1) Claims paid	**9b(1)**	559,000		
(2) Increase (decrease) in claim reserves	**9b(2)**	453,522		
(3) Incurred claims (add (1) and (2))			**9b(3)**	1,012,522
(4) Claims charged			**9b(4)**	1,012,522
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	73,874		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	71,920		
(E) Taxes	**9c(1)(E)**	14,626		
(F) Charges for risks or other contingencies	**9c(1)(F)**	40,134		
(G) Other retention charges	**9c(1)(G)**	0		
(H) Total retention			**9c(1)(H)**	200,554
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	36,360
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
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	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).	2025
Department of Labor Employee Benefit Security Administration	▶ File as an attachment to Form 5500.	This Form is Open to Public Inspection.
Pension Benefit Guaranty Corporation		

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

A Name of plan
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

(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

(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)

BlueAdvantage Administrations of Arkansas **71-0226428**
PO Box 3743
US **Little Rock** **AR 72203**

(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?
12 13 50	**None**	**1,173,189**	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

Metropolitan Life Insurance Company **13-5581829**

(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?
12 13 50	**None**	**141,381**	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

Capital Rx **35-2612946**

(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?
12 13 50	**None**	**76,634**	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:

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)

Express Scripts **43-1420563**

(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?
12 13 50	**None**	**34,814**	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

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
Washington Regional Medical System Welfare Benefit Plan

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Washington Regional Medical Center

D Employer Identification Number (EIN)
71-0664687

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)	1,582,460	1,686,529
(2) Participant contributions	1b(2)	613,329	660,321
(3) Other	1b(3)	2,585,010	1,718,400
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	114,031	3,204,444
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(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)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	4,894,830	7,269,694
Liabilities			
g Benefit claims payable	1g	2,001,543	2,363,392
h Operating payables	1h	0	
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	2,001,543	2,363,392
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	2,893,287	4,906,302

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)	22,081,751	
(B) Participants	2a(1)(B)	8,679,748	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		30,761,499
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	95,455	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		95,455
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(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)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		30,856,954
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	27,266,307	
(2) To insurance carriers for the provision of benefits	2e(2)	60,120	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		27,326,427
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1,517,512	
(3) Recordkeeping fees	2i(3)		
(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)		1,517,512
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		28,843,939
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		2,013,015
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) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropiate 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) [X] 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: **Forvis Mazars, LLP** **(2)** EIN: **44-0160260**

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, 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 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		3,000,000
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			
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			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] 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 _____.

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4i – Schedule of Assets (Held at End of Year)
December 31, 2025

Identity of Issue	Description of Investment	Cost	Current Value
Bank of Fayetteville Money Market Fund	Money Market Fund, 3,204,443.92 shares	$ 3,204,444	$ 3,204,444

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
		Category (i) – Individual Transactions in Excess of 5% of Plan Assets					
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 318,239 shares	$ 318,239	$ -	$ -	$ 318,239	$ 318,239	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 454,360 shares	$ 454,360	$ -	$ -	$ 454,360	$ 454,360	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 475,104 shares	$ 475,104	$ -	$ -	$ 475,104	$ 475,104	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 848,350 shares	$ 848,350	$ -	$ -	$ 848,350	$ 848,350	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,014,298 shares	$ 1,014,298	$ -	$ -	$ 1,014,298	$ 1,014,298	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,041,349 shares	$ 1,041,349	$ -	$ -	$ 1,041,349	$ 1,041,349	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,044,299 shares	$ 1,044,299	$ -	$ -	$ 1,044,299	$ 1,044,299	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,051,584 shares	$ 1,051,584	$ -	$ -	$ 1,051,584	$ 1,051,584	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,053,898 shares	$ 1,053,898	$ -	$ -	$ 1,053,898	$ 1,053,898	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,059,626 shares	$ 1,059,626	$ -	$ -	$ 1,059,626	$ 1,059,626	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,066,560 shares	$ 1,066,560	$ -	$ -	$ 1,066,560	$ 1,066,560	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,071,861 shares	$ 1,071,861	$ -	$ -	$ 1,071,861	$ 1,071,861	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,072,271 shares	$ 1,072,271	$ -	$ -	$ 1,072,271	$ 1,072,271	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,171,308 shares	$ 1,171,308	$ -	$ -	$ 1,171,308	$ 1,171,308	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,175,898 shares	$ 1,175,898	$ -	$ -	$ 1,175,898	$ 1,175,898	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,176,362 shares	$ 1,176,362	$ -	$ -	$ 1,176,362	$ 1,176,362	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,177,231 shares	$ 1,177,231	$ -	$ -	$ 1,177,231	$ 1,177,231	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,177,634 shares	$ 1,177,634	$ -	$ -	$ 1,177,634	$ 1,177,634	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,181,553 shares	$ 1,181,553	$ -	$ -	$ 1,181,553	$ 1,181,553	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,182,113 shares	$ 1,182,113	$ -	$ -	$ 1,182,113	$ 1,182,113	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,185,495 shares	$ 1,185,495	$ -	$ -	$ 1,185,495	$ 1,185,495	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,185,973 shares	$ 1,185,973	$ -	$ -	$ 1,185,973	$ 1,185,973	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,186,682 shares	$ 1,186,682	$ -	$ -	$ 1,186,682	$ 1,186,682	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,187,652 shares	$ 1,187,652	$ -	$ -	$ 1,187,652	$ 1,187,652	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,191,305 shares	$ 1,191,305	$ -	$ -	$ 1,191,305	$ 1,191,305	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 1,191,554 shares	$ 1,191,554	$ -	$ -	$ 1,191,554	$ 1,191,554	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,192,574 shares	$ 1,192,574	$ -	$ -	$ 1,192,574	$ 1,192,574	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,202,049 shares	$ 1,202,049	$ -	$ -	$ 1,202,049	$ 1,202,049	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,202,461 shares	$ 1,202,461	$ -	$ -	$ 1,202,461	$ 1,202,461	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,204,879 shares	$ 1,204,879	$ -	$ -	$ 1,204,879	$ 1,204,879	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,207,234 shares	$ 1,207,234	$ -	$ -	$ 1,207,234	$ 1,207,234	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 1,216,296 shares	$ 1,216,296	$ -	$ -	$ 1,216,296	$ 1,216,296	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 247,177 shares	$ -	$ 247,177	$ -	$ 247,177	$ 247,177	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 250,062 shares	$ -	$ 250,062	$ -	$ 250,062	$ 250,062	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 263,481 shares	$ -	$ 263,481	$ -	$ 263,481	$ 263,481	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 264,761 shares	$ -	$ 264,761	$ -	$ 264,761	$ 264,761	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 268,355 shares	$ -	$ 268,355	$ -	$ 268,355	$ 268,355	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 271,187 shares	$ -	$ 271,187	$ -	$ 271,187	$ 271,187	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 273,978 shares	$ -	$ 273,978	$ -	$ 273,978	$ 273,978	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 275,400 shares	$ -	$ 275,400	$ -	$ 275,400	$ 275,400	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 279,283 shares	$ -	$ 279,283	$ -	$ 279,283	$ 279,283	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 291,421 shares	$ -	$ 291,421	$ -	$ 291,421	$ 291,421	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 292,447 shares	$ -	$ 292,447	$ -	$ 292,447	$ 292,447	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 292,616 shares	$ -	$ 292,616	$ -	$ 292,616	$ 292,616	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 296,283 shares	$ -	$ 296,283	$ -	$ 296,283	$ 296,283	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 299,754 shares	$ -	$ 299,754	$ -	$ 299,754	$ 299,754	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 313,386 shares	$ -	$ 313,386	$ -	$ 313,386	$ 313,386	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 321,714 shares	$ -	$ 321,714	$ -	$ 321,714	$ 321,714	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 324,829 shares	$ -	$ 324,829	$ -	$ 324,829	$ 324,829	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 328,047 shares	$ -	$ 328,047	$ -	$ 328,047	$ 328,047	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 348,936 shares	$ -	$ 348,936	$ -	$ 348,936	$ 348,936	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 350,435 shares	$ -	$ 350,435	$ -	$ 350,435	$ 350,435	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 355,513 shares	$ -	$ 355,513	$ -	$ 355,513	$ 355,513	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 359,682 shares	$ -	$ 359,682	$ -	$ 359,682	$ 359,682	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Bank of Fayetteville Money Market Sweep	Money Market Account, 363,939 shares	$ -	$ 363,939	$ -	$ 363,939	$ 363,939	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 368,112 shares	$ -	$ 368,112	$ -	$ 368,112	$ 368,112	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 375,500 shares	$ -	$ 375,500	$ -	$ 375,500	$ 375,500	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 376,643 shares	$ -	$ 376,643	$ -	$ 376,643	$ 376,643	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 380,556 shares	$ -	$ 380,556	$ -	$ 380,556	$ 380,556	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 381,754 shares	$ -	$ 381,754	$ -	$ 381,754	$ 381,754	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 383,561 shares	$ -	$ 383,561	$ -	$ 383,561	$ 383,561	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 384,233 shares	$ -	$ 384,233	$ -	$ 384,233	$ 384,233	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 388,164 shares	$ -	$ 388,164	$ -	$ 388,164	$ 388,164	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 388,306 shares	$ -	$ 388,306	$ -	$ 388,306	$ 388,306	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 400,174 shares	$ -	$ 400,174	$ -	$ 400,174	$ 400,174	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 401,085 shares	$ -	$ 401,085	$ -	$ 401,085	$ 401,085	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 410,800 shares	$ -	$ 410,800	$ -	$ 410,800	$ 410,800	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 411,810 shares	$ -	$ 411,810	$ -	$ 411,810	$ 411,810	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 413,391 shares	$ -	$ 413,391	$ -	$ 413,391	$ 413,391	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 414,242 shares	$ -	$ 414,242	$ -	$ 414,242	$ 414,242	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 417,363 shares	$ -	$ 417,363	$ -	$ 417,363	$ 417,363	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 418,474 shares	$ -	$ 418,474	$ -	$ 418,474	$ 418,474	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 418,904 shares	$ -	$ 418,904	$ -	$ 418,904	$ 418,904	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 420,494 shares	$ -	$ 420,494	$ -	$ 420,494	$ 420,494	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 423,442 shares	$ -	$ 423,442	$ -	$ 423,442	$ 423,442	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 435,093 shares	$ -	$ 435,093	$ -	$ 435,093	$ 435,093	$ -

Washington Regional Medical System Welfare Benefit Plan
EIN 71-0664687 PN 501
Schedule H, Line 4j – Schedule of Reportable Transactions
Year Ended December 31, 2025 **(Continued)**

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 441,046 shares	$ -	$ 441,046	$ -	$ 441,046	$ 441,046	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 451,556 shares	$ -	$ 451,556	$ -	$ 451,556	$ 451,556	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 467,862 shares	$ -	$ 467,862	$ -	$ 467,862	$ 467,862	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 497,150 shares	$ -	$ 497,150	$ -	$ 497,150	$ 497,150	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 504,166 shares	$ -	$ 504,166	$ -	$ 504,166	$ 504,166	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 515,313 shares	$ -	$ 515,313	$ -	$ 515,313	$ 515,313	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 552,384 shares	$ -	$ 552,384	$ -	$ 552,384	$ 552,384	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 558,868 shares	$ -	$ 558,868	$ -	$ 558,868	$ 558,868	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 561,306 shares	$ -	$ 561,306	$ -	$ 561,306	$ 561,306	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 576,126 shares	$ -	$ 576,126	$ -	$ 576,126	$ 576,126	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 585,378 shares	$ -	$ 585,378	$ -	$ 585,378	$ 585,378	$ -

Identity	Description	Purchase Price	Selling Price	Expenses Incurred With Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Bank of Fayetteville Money Market Sweep	Money Market Account, 611,617 shares	$ -	$ 611,617	$ -	$ 611,617	$ 611,617	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 657,992 shares	$ -	$ 657,992	$ -	$ 657,992	$ 657,992	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 670,617 shares	$ -	$ 670,617	$ -	$ 670,617	$ 670,617	$ -
	Category (iii) – Series of Transactions in Excess of 5% of Plan Assets						
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 22,920,932 shares	$ -	$ 22,920,932	$ -	$ 22,920,932	$ 22,920,932	$ -
Federated Treasury Obligation Fund #398	Money Market Mutual Fund, 27,156,318 shares	$ 27,156,318	$ -	$ -	$ 27,156,318	$ 27,156,318	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 9,045,767 shares	$ -	$ 9,045,767	$ -	$ 9,045,767	$ 9,045,767	$ -
Bank of Fayetteville Money Market Sweep	Money Market Account, 7,813,777 shares	$ 7,813,777	$ -	$ -	$ 7,813,777	$ 7,813,777	$ -