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
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/1963

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
OLEAN GENERAL HOSPITAL

515 MAIN STREET
OLEAN, NY 14760-1513

2b Employer Identification Number (EIN)
16-0743102

2c Plan Sponsor's telephone number
716-375-6104

2d Business code (see instructions)
622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2026	LUCIAN TRUDEAU
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a	Plan administrator's name and address [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:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	809
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)**	300
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	294
b	Retired or separated participants receiving benefits	**6b**	110
c	Other retired or separated participants entitled to future benefits	**6c**	379
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	783
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	9
f	Total. Add lines **6d** and **6e**.	**6f**	792
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**	13
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:

1A

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

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1) [ ]	Insurance	**(1)** [ ]	Insurance
(2) [ ]	Code section 412(e)(3) insurance contracts	**(2)** [ ]	Code section 412(e)(3) insurance contracts
(3) [X]	Trust	**(3)** [X]	Trust
(4) [ ]	General assets of the sponsor	**(4)** [ ]	General assets of the sponsor

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

a Pension Schedules

- **(1)** [X] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [X] **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)** [ ] **A** (Insurance Information) – Number Attached _____
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

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

▶ **Round off amounts to nearest dollar.**

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

A Name of plan
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
OLEAN GENERAL HOSPITAL

D Employer Identification Number (EIN)
16-0743102

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [ ] 101-500 [X] More than 500

Part I Basic Information

1 Enter the valuation date: Month 01 Day 01 Year 2025

2 Assets:

a Market value	**2a**	21061973
b Actuarial value	**2b**	20089041

3 Funding target/participant count breakdown

	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	119	5471881	5471881
b For terminated vested participants	390	9456729	9456729
c For active participants	316	9468524	9603384
d Total	825	24397134	24531994

4 If the plan is in at-risk status, check the box and complete lines (a) and (b) [ ]

a Funding target disregarding prescribed at-risk assumptions	**4a**	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	**4b**	

5 Effective interest rate	**5**	5.37 %
6 Target normal cost		
a Present value of current plan year accruals	**6a**	854320
b Expected plan-related expenses	**6b**	646083
c Target normal cost	**6c**	1500403

Statement by Enrolled Actuary

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

SIGN HERE

Signature of actuary

10/07/2026
Date

GREGORY M. STUMP
Type or print name of actuary

26-06998
Most recent enrollment number

BOOMERSHINE CONSULTING GROUP L.L.C.
Firm name

410-418-5525
Telephone number (including area code)

3300 N. RIDGE RD. SUITE 300
ELLICOTT CITY, MD 21043

Address of the firm

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

Part II Beginning of Year Carryover and Prefunding Balances

		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)		
9	Amount remaining (line 7 minus line 8)	0	0
10	Interest on line 9 using prior year's actual return of 10.81 %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		0
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of 5.25 %		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections		0
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages

14	Funding target attainment percentage	14	81.88 %
15	Adjusted funding target attainment percentage	15	81.88 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	80.49 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/16/2025	442291	0	01/20/2026	338164	0
04/16/2025	34709	0	01/20/2026	138836	0
07/15/2025	407582	0	09/11/2026	136000	0
07/15/2025	69418	0			
10/20/2025	372873	0			
10/20/2025	104127	0			
			Totals ► 18(b)	2044000	18(c) 0

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a	Contributions allocated toward unpaid minimum required contributions from prior years	19a	
b	Contributions made to avoid restrictions adjusted to valuation date	19b	
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	1966625

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? [X] Yes [ ] No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? [ ] Yes [X] No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

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

21 Discount rate:

a Segment rates:	1st segment: 5.00 %	2nd segment: 5.27 %	3rd segment: 5.50 %	☐ N/A, full yield curve used

b Applicable month (enter code)	**21b**	0
22 Weighted average retirement age	**22**	65

23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No

26 Demographic and benefit information

a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ☒ Yes ☐ No

b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ☐ Yes ☒ No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	**27**	

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

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

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6c)	**31a**	1500403
b Excess assets, if applicable, but not greater than line 31a	**31b**	0

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	4442953	465332
b Waiver amortization installment		

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____)_and the waived amount	**33**	
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)	**34**	1965735

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0

36 Additional cash requirement (line 34 minus line 35)	**36**	1965735
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	**37**	1966625

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36)	**38a**	890
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	**38b**	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	**39**	0
40 Unpaid minimum required contributions for all years	**40**	0

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

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

SCHEDULE C (Form 5500)	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
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
OLEAN GENERAL HOSPITAL

D Employer Identification Number (EIN)
16-0743102

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

DRAKE CAPITAL ADVISORS L.L.C.

06-1609791

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

EVANSTON CAPITAL MANAGEMENT, LLC

1560 SHERMAN AVE
SUITE 960
EVANSTON, IL 60201

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

FIRST PACIFIC ADVISORS, LP

20-1362771

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

HARTFORD FUNDS MANAGEMENT COMPANY

46-1470670

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

THE VANGUARD GROUP, INC.

23-1945930

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

BLACKROCK ADVISORS, LLC

23-2784752

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

BLACKROCK FUND ADVISORS

23-2784752

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

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

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

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

BOOMERSHINE CONSULTING GROUP, LLC

20-8714603

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	N/A	196714	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PRIME, BUCHHOLZ & ASSOCIATES

02-0426421

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	N/A	33990	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

COMMUNITY BANK

15-0436580

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21	N/A	23850	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

STATE STREET GLOBAL ADVISORS

04-1867445

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51 18 19	N/A	7782	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

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

PARNASSUS INVESTMENTS

1 MARKET STREET
SUITE 1600
SAN FRANCISCO, CA 94105

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

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

T. ROWE PRICE ASSOCIATES, INC.

100 EAST PRATT STREET
BALTIMORE, MD 21202

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

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

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

HARBOR CAPITAL ADVISOR, INC.

34-1953397

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

OMB No. 1210-0110

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
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
OLEAN GENERAL HOSPITAL

D Employer Identification Number (EIN)
16-0743102

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SSGA REAL ASSET NL FUND (ZVBQ)

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
90-0337987-291	C	2333939

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

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
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
OLEAN GENERAL HOSPITAL

D Employer Identification Number (EIN)
16-0743102

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	442622	334802
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	10707	10886
(5) Partnership/joint venture interests	1c(5)	3525139	4151011
(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)	1968292	2333939
(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)	14015639	16345217
(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	19962399	23175855
Liabilities			
1g Benefit claims payable	1g		
1h Operating payables	1h		
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	19962399	23175855

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)	2540000	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		2540000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	38686	
(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)		38686
(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)	806486	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		806486
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	1496	
(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)		1496
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	2241526	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		2241526

		(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)		279855
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		5908049
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	2159768	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		2159768
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	41772	
(6) Bank or trust company trustee/custodial fees	2i(6)	23850	
(7) Actuarial fees	2i(7)	196714	
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	272489	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		534825
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		2694593
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		3213456
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) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] 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: LUMDSDEN AND MCCORMICK **(2)** EIN: 16-0765486

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) [ ] This form is filed for a CCT, PSA, DCG or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**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		1500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**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.) ..... [X] Yes [ ] No [ ] Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 602425.

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection.

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

A Name of plan
PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
OLEAN GENERAL HOSPITAL

D Employer Identification Number (EIN)
16-0743102

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1**

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 15-0436580

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

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year **3** 30

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

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

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ last contributing employer ☐ alternative ☐ reasonable approximation (see instructions for required attachment)	**14a**	
b The plan year immediately preceding the current plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14b**	
c The second preceding plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14c**	

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

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

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

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

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

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

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

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

a Enter the percentage of plan assets held as:
Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%
High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
☐ 0-5 years ☐ 5-10 years ☐ 10-15 years ☐ 15 years or more

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

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

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

☐ Yes.

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

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

☐ No. Other. Provide explanation._____

Part VII IRS Compliance Questions

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

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

☐ Design-based safe harbor method

☐ "Prior year" ADP test

☐ "Current year" ADP test

☐ N/A

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

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

FINANCIAL STATEMENTS WITH ADDITIONAL INFORMATION

December 31, 2025

Lumsden McCormick LLP
CERTIFIED PUBLIC ACCOUNTANTS

Cyclorama Building | 369 Franklin Street | Buffalo, NY 14202
p: 716.856.3300 | f: 716.856.2524 | www.LumsdenCPA.com

INDEPENDENT AUDITORS' REPORT

The Plan Administrator
Pension Program for Employees of Olean General Hospital

Opinion

We have audited the financial statements of Pension Program For Employees of Olean General Hospital (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits as of December 31, 2025 and 2024 and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, information regarding the Plan's net assets available for benefits as of December 31, 2025 and 2024, and the changes in its net assets available for benefits for the years then ended in accordance with accounting principles generally accepted in the United States of America (GAAP).

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditors' Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplemental Schedules Required by ERISA

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

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

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

Lumsden & McCormick, LLP

October 9, 2026

Statements of Net Assets Available for Benefits

December 31,	2025	2024
Investments:		
Mutual funds	$ 16,345,218	$ 14,015,639
Money market and similar funds	334,802	442,622
Limited partnership investment funds	4,151,012	3,525,139
Common collective trust	2,333,939	1,968,292
Common stock	10,886	10,707
	23,175,857	19,962,399
Receivables - employer contributions	613,000	1,109,000
Net assets available for benefits	$ 23,788,857	$ 21,071,399

See accompanying notes.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

Statements of Changes in Net Assets Available for Benefits

For the years ended December 31,	2025	2024
Additions to net assets:		
Investment income:		
Net appreciation in fair value of investments	$ 2,522,879	$ 1,462,048
Interest and dividends	845,172	556,018
	3,368,051	2,018,066
Less investment expenses	41,772	37,026
	3,326,279	1,981,040
Employer contributions	2,044,000	2,411,000
Total additions	5,370,279	4,392,040
Deductions from net assets:		
Benefits paid to participants	2,159,768	2,201,030
Administrative expenses	493,053	609,057
Total deductions	2,652,821	2,810,087
Change in net assets available for benefits	2,717,458	1,581,953
Balance - beginning	21,071,399	19,489,446
Balance - ending	$ 23,788,857	$ 21,071,399

See accompanying notes.

Notes to Financial Statements

1. Plan Description:

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

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

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

2. Significant Accounting Policies:

Basis of Accounting:

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

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

Investment Valuation and Income Recognition:

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

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

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Unrealized appreciation or depreciation on investments is charged or credited to the net assets of the Plan.

Actuarial Method and Funding Policy:

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

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

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

Use of Estimates:

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

Subsequent Events:

The Plan has evaluated events and transactions for potential recognition or disclosure in the financial statements through October 9, 2026, the date the financial statements were available to be issued.

3. Administrative Expenses:

Various Plan administrative expenses are paid by the Hospital. Trustee fees and professional fees totaling $220,564 and $238,600 were paid by the Plan for the years ended December 31, 2025 and 2024. The Plan paid Pension Benefit Guaranty Corporation (PBGC) premiums totaling $272,489 and $370,457 for the years ended December 31, 2025 and 2024.

4. Tax Status:

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

5. Termination of the Plan:

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

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

The actuarial present value of accumulated Plan benefits is determined by an actuary and is that amount that results from applying actuarial assumptions to adjust the accumulated plan benefits to reflect the time value of money between the valuation date and the expected date of payment. The significant actuarial assumptions used in the valuation as of December 31, 2024 are (a) life expectancy of participants (PRI-2012 White Collar Retiree/Contingent Survivor/Employee and Disability tables, with MP-2021), (b) retirement age assumptions (a normal retirement at age 65), (c) salary increases (3.50% per year plus step increase ranging from 1.50% – 7.30% based on years of service for participants covered by a collective bargaining agreement who continue to accrue benefits in the Plan), and (d) investment return of 6.75%.

For the years ended December 31, 2025 and 2024, the actuarial present value of accumulated plan benefits is presented as of the beginning of the plan year. The actuarial present value of accumulated plan benefits at December 31, 2024 is:

Vested:	
Participants currently receiving payments	$ 5,131,827
Other participants	17,085,184
	22,217,011
Non-vested	96,152
Total actuarial present value	$ 22,313,163

The change in the actuarial present value of all accrued benefits during the year ended December 31, 2024 is shown below:

Value as of December 31, 2023	$ 22,242,854
Benefit payments	(2,201,030)
Assumption changes	438,189
Other (includes benefits accumulated)	1,833,150
Value as of December 31, 2024	$ 22,313,163

Assumption changes that impacted the value of accumulated plan benefits above include updated IRS mortality tables, changes in lump sum conversion interest rates from 2023, adjusted funding segment rates (4.75%, 4.96%, and 5.59%) to 2024 adjusted funding segment rates (5.00%, 5.27%, and 5.50%), change in pre/post-retirement mortality, and a change in the discount rate (5.37% in 2024; 5.25% in 2023).

7. Risks and Uncertainties:

The Plan invests in various investment securities. Investment securities are exposed to risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

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

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

Community Bank, N.A. is an investment custodian. Community Bank, N.A. proprietary money market and similar funds totaled $334,802 and $442,622 at December 31, 2025 and 2024.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102
Plan Number 001 - Supplementary Information

Schedule H, Line 4i
Schedule of Assets Held for Investment Purposes at December 31, 2025

(a)	(b) Identity of Issue	(c) Shares/ Par Value	(d) Cost/ Book Value	(e) Current Value
	Mutual funds:			
	Vanguard Total Stock Market Index Fund Admiral Shares	29,974	$ 2,622,688	$ 4,891,714
	T. Rowe Price Total Return Fund Total Return I	247,125	2,510,457	2,085,739
	Harbor Diversified International All Cap Fund Institutional Class	147,828	1,550,064	2,143,500
	Vanguard Intermediate - Term Treasury Fund Admiral Shares	191,501	2,182,101	1,926,500
	Vanguard Total International Stock Index Fund Admiral	55,743	1,568,708	2,259,243
	Parnassus Core Equity Fund - Institutional Shares	27,204	1,349,439	1,527,227
	Hartford World Bond Fund Class Y	70,497	744,726	705,672
	FPA Crescent Fund Supra Institutional Class	7,369	286,136	317,955
	BlackRock Event Driven Equity Fund Institutional Shares	22,952	229,494	238,699
	BlackRock Strategic Income Opportunities Portfolio Investor A Shares	25,483	258,452	248,969
	Total mutual funds			16,345,218
	Money market and similar funds:			
*	CBNA Daily Trust Sweep		334,802	334,802
	Limited partnership investment funds:			
	Weatherlow Offshore Fund II LTD	1,009	1,168,720	2,529,601
	Drake Capital Offshore Partners, L.P.	750,000	750,000	1,621,411
	Total limited partnership investment funds			4,151,012
	Common Collective Trust:			
	SSGA Real Asset NL Fund	108,778	1,317,515	2,333,939
	Common stock:			
	MetLife		137	10,886
				$ 23,175,857

* These investments are with parties-in-interest.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102
Plan Number 001 - Supplementary Information

Schedule H, Line 4j
Schedule of Reportable Transactions for the year ended December 31, 2025

(a) Identity of Party Involved	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value on Transaction Date	(i) Net Gain or (Loss)
Series of transactions in excess of 5% of Plan Assets:						
Community Bank, N.A.	Money Market	$ 2,694,593	$ -	$ 2,694,593	$ 2,694,593	$ -
Community Bank, N.A.	Money Market	$ -	$ 2,802,413	$ 2,802,413	$ 2,802,413	$ -

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

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

▶ **Round off amounts to nearest dollar.**

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

A Name of plan
Pension Program for Employees of Olean General Hospital

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
Olean General Hospital

D Employer Identification Number (EIN)
16-0743102

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [ ] 101-500 [X] More than 500

Part I Basic Information

1 Enter the valuation date: Month 1 Day 1 Year 2025

2 Assets:

a Market value	**2a**	21,061,973
b Actuarial value	**2b**	20,089,041

3 Funding target/participant count breakdown

	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	119	5,471,881	5,471,881
b For terminated vested participants	390	9,456,729	9,456,729
c For active participants	316	9,468,524	9,603,384
d Total	825	24,397,134	24,531,994

4 If the plan is in at-risk status, check the box and complete lines (a) and (b) [ ]

a Funding target disregarding prescribed at-risk assumptions	**4a**	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	**4b**	
5 Effective interest rate	**5**	5.37 %
6 Target normal cost		
a Present value of current plan year accruals	**6a**	854,320
b Expected plan-related expenses	**6b**	646,083
c Target normal cost	**6c**	1,500,403

Statement by Enrolled Actuary

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

SIGN HERE

Signature of actuary

10/7/2026
Date

GREGORY M. STUMP
Type or print name of actuary

26-06998
Most recent enrollment number

BOOMERSHINE CONSULTING GROUP L.L.C.
Firm name

(410) 418-5525
Telephone number (including area code)

3300 N. RIDGE RD. SUITE 300

ELLICOTT CITY MD 21043
Address of the firm

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

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Line 19

SCHEDULE SB, LINE 19 - DISCOUNTED EMPLOYER CONTRIBUTIONS

Contribution	Date	Plan Year	Adjustment Interest Rate	Adjustment Period	Adjustment Interest Rate	Adjustment Period	Discounted Contribution
442,291	4/16/2025	2025	5.37%	4/15/2025 to 1/1/2025	10.37%	4/16/2025 to 4/15/2025	435,630
34,709	4/16/2025	2025	5.37%	4/16/2025 to 1/1/2025			34,190
407,582	7/15/2025	2025	5.37%	7/15/2025 to 1/1/2025			396,349
69,418	7/15/2025	2025	5.37%	7/15/2025 to 1/1/2025			67,504
372,873	10/20/2025	2025	5.37%	10/15/2025 to 1/1/2025	10.37%	10/20/2025 to 10/15/2025	357,364
104,127	10/20/2025	2025	5.37%	10/15/2025 to 1/1/2025			99,859
338,164	1/20/2026	2025	5.37%	1/15/2026 to 1/1/2025	10.37%	1/20/2026 to 1/15/2026	319,854
138,836	1/20/2026	2025	5.37%	1/15/2026 to 1/1/2025			131,402
136,000	9/11/2026	2025	5.37%	9/11/2026 to 1/1/2025			124,473
2,044,000							1,966,625

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Line 22

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

Age (Input)	Rate (Input)	Retiring (Calc)	Remaining (Calc)	Weighted (Calc)	
55	0.30%	0.003000	0.997000	0.165000	
56	0.30%	0.002991	0.994009	0.167496	
57	0.30%	0.002982	0.991027	0.169976	
58	0.30%	0.002973	0.988054	0.172439	
59	2.50%	0.024701	0.963353	1.457379	
60	2.50%	0.024084	0.939269	1.445029	
61	2.50%	0.023482	0.915787	1.432385	
62	5.00%	0.045789	0.869998	2.838940	
63	15.00%	0.130500	0.739498	8.221478	
64	15.00%	0.110925	0.628573	7.099181	
65	50.00%	0.314287	0.314287	20.428633	
66	40.00%	0.125715	0.188572	8.297168	
67	12.00%	0.022629	0.165943	1.516119	
68	12.00%	0.019913	0.146030	1.354098	
69	50.00%	0.073015	0.073015	5.038040	
70	100.00%	0.073015	0.000000	5.111055	Sum = 64.914414 = Weighted Average Retirement Age

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Part V

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

1. Actuarial Assumptions:

The non-prescribed demographic assumptions used in the valuation are based on an assumption review completed in 2025. As a result of the review, the retirement rates, withdrawal rates, benefit option elections, and salary scale were revised. The change in assumptions resulted in a very small increase in liability.

(a) Interest Rates:

ERISA Funding (reflecting Pension Relief through IIJA):	1/1/2025
First Segment	5.00%
Second Segment	5.27%
Third Segment	5.50%
Plan's Effective Interest Rate	5.37%

(b) Mortality Before and After Retirement:

ERISA funding/PBGC premium/4010 filing: IRS 2025 Annuitant/Non-annuitant tables

The IRS 2024 Annuitant/Non-annuitant tables were used last year.

(c) Salary Scale: Increases from Collective Bargaining Agreement

3.50% per year (2.00% prior assumption), plus the following step increases:

Service	Increase	Service	Increase
1	3.50%	15	2.70%
2	3.10%	20	7.30%
5	6.40%	25	3.80%
7	2.90%	30	1.50%
10	3.80%		

(d) Lump sum conversion:

ERISA funding/PBGC premium/4010 filing: 2025 funding segment rates, IRS 2025 417(e) mortality

2024 funding segment rates, IRS 2024 417(e) mortality used last year

(e) Social Security Taxable Wage Base Increase: 2.00% per year

(f) Benefit Payments: 85% of active and terminated vested participants are assumed to elect the lump sum option (70% last year) and 15% are assumed to elect the life annuity option (30% last year). For individuals who began participating on or after February 1, 2010, 100% are assumed to elect the life annuity option. Future lump sum payments are valued using the funding interest rates and the unisex mortality table from IRC Section 417(e).

(g) Benefit Commencement for Deferred Vested Participants: at normal retirement date, or immediately if past normal retirement date

(h) Benefit Commencement for Active Participants: Retirement - based on retirement rates; Death - at participant's earliest retirement date; Withdrawal - at participant's normal retirement date

(i) Interest credit on Employee Contributions: 5.10% per year (120% Annual AFR Mid-Term January 2025) (5.25% used for 2024 (120% Annual AFR Mid-Term January 2024))

(j) Marriage and Age of Spouse: 75% of employees are assumed to be married. Wives are assumed to be three years younger than their husbands.

(k) Withdrawal Before Retirement:

Age	Rates	Age	Rates
20-24	19.00%	45-49	15.00%
25-29	19.00%	50-54	10.00%
30-34	19.00%	55-59	5.00%
35-39	15.00%	60-64	13.00%
40-44	15.00%	65-69	10.00%

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

(l) Retirement Rates:

Age	Rate	Age	Rate
55 - 58	0.3%	66	40.0%
59 - 61	2.5%	67 - 68	12.0%
62	5.0%	69	50.0%
63 - 64	15.0%	70+	100.0%
65	50.0%		

(m) All participants are included in plan costs.

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

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

2. Actuarial Cost Method:

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

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

Target Normal Cost (TNC) is defined as the present value of all benefits that have accrued or are expected to be accrued during the plan year January 1, 2025 - December 31, 2025. Target Normal Cost also includes the plan-related expenses expected to be paid from Plan assets during the Plan Year.

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

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

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

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Part V

SCHEDULE SB, PART V - SUMMARY OF PLAN PROVISIONS

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

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

VALUATION DATE: January 1.

PLAN YEAR: January 1 through December 31.

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

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

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

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

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

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

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

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Part V

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

RETIREMENT DATES:

(a) Normal Retirement: A participant's Normal Retirement Date is the first day of the month coincident with or next following the later of age 65 and the fifth anniversary of Plan participation.

(b) Early Retirement: A participant may elect early retirement after attaining age 55 and completing 10 years of Vesting Service.

(c) Disability Retirement: A participant will be eligible for disability retirement after becoming totally and permanently disabled, as defined under the Social Security Act, and completing at least 10 years of Vesting Service.

(d) Deferred Retirement: A participant may continue to work beyond Normal Retirement Date.

AMOUNT OF RETIREMENT BENEFIT:

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

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

(b) Early Retirement: The early retirement benefit is calculated in the same way as a normal retirement benefit. If payments begin prior to Normal Retirement Date, the amount of benefit will be reduced. The reduction is equal to the greater of 0.5% for each month payments precede Normal Retirement Date or the actuarially equivalent benefit, with a maximum early retirement factor from Table 1 in the Plan document.

(c) Disability Retirement: The disability retirement benefit is calculated in the same way as a normal retirement benefit. If payments begin prior to Normal Retirement Date, the amount of benefit will be reduced. The reduction is equal to the greater of 0.5% for each month payments precede Normal Retirement Date or the actuarially equivalent benefit.

(d) Deferred Retirement: The retirement benefit payable when a participant actually retires will be based on Benefit Service and final average compensation at that time. The benefit is subject to the suspension of benefit regulations.

OPTIONAL FORMS OF BENEFIT PAYMENT:

(a) Life Annuity: Monthly payments will be made to the retired participant during his lifetime. After his death, no further payments are made.

(b) Joint and Contingent Annuitant: Reduced monthly payments will be made to the retired participant during his lifetime. After his death, payments of 100%, 75%, 66-2/3% or 50% of the participant's payment will be continued to the designated beneficiary for the beneficiary's lifetime.

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

(c) Social Security Adjustment: Increased monthly payments will be made to the retired participant during his lifetime and prior to the date that Social Security payments begin. After Social Security payments start, while the participant is still living, monthly payments from the Plan will be reduced so that the total monthly payments before and after Social Security begins will be approximately equal.

(d) Lump Sum: For retired participants, in lieu of receiving monthly payments, a single payment of the present value of the benefit may be made. This lump sum option is not available to participants who entered the Plan on or after February 1, 2010. However, a lump sum valued at $7,000 or less may be made to any terminated participant.

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

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

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

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

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
Pension Program for Employees of
Olean General Hospital

1b Three-digit plan number (PN) ▸ 001

1c Effective date of plan 01/01/1963

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
Olean General Hospital

515 Main Street

Olean NY 14760-1513

2b Employer Identification Number (EIN) 16-0743102

2c Plan Sponsor's telephone number (716) 375-6104

2d Business code (see instructions) 622000

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

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

SIGN HERE	Signature of plan administrator	Date 10/14/2024	Enter name of individual signing as plan administrator: Lucian Trudeau
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

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Line 26a

Schedule of Active Participant Data

YEARS OF CREDITED SERVICE

	Under 1		1 to 4		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34		35 to 39		40 & up	
Attained Age	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**	**No.**	**Average Comp.**
Under 25	1		14		0		0		0		0		0		0		0		0	
25 to 29	5		17		4		0		0		0		0		0		0		0	
30 to 34	3		22		3		1		0		0		0		0		0		0	
35 to 39	8		19		13		3		1		0		0		0		0		0	
40 to 44	3		16		7		6		2		0		0		0		0		0	
45 to 49	0		14		10		4		1		1		1		0		0		0	
50 to 54	0		6		6		8		6		4		0		2		0		0	
55 to 59	2		7		8		6		8		12		1		5		1		0	
60 to 64	1		6		6		6		5		11		3		0		4		0	
65 to 69	0		0		3		0		5		1		0		1		0		0	
70 & up	0		1		0		1		0		0		0		1		0		0	

Plan Name: Pension Program for Employees of Olean General Hospital
EIN: 16-0743102
Plan No.: 001
2025 Schedule SB, Line 32

SCHEDULE SB, LINE 32 - SCHEDULE OF AMORTIZATION BASES

Valuation Date	Shortfall Base	Remaining Base as of 1/1/2025	Number of Yrs Remaining	Payment
1/1/2022	1,977,240	1,683,217	12	182,720
1/1/2023	2,869,194	2,562,449	13	262,763
1/1/2024	362,177	339,787	14	33,102
1/1/2025	(142,500)	(142,500)	15	(13,253)
Total:		4,442,953		465,332

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102
Plan Number 001 - Supplementary Information

Schedule H, Line 4i
Schedule of Assets Held for Investment Purposes at December 31, 2025

(a)	(b) Identity of Issue	(c) Shares/ Par Value	(d) Cost/ Book Value	(e) Current Value
	Mutual funds:			
	Vanguard Total Stock Market Index Fund Admiral Shares	29,974	$ 2,622,688	$ 4,891,714
	T. Rowe Price Total Return Fund Total Return I	247,125	2,510,457	2,085,739
	Harbor Diversified International All Cap Fund Institutional Class	147,828	1,550,064	2,143,500
	Vanguard Intermediate - Term Treasury Fund Admiral Shares	191,501	2,182,101	1,926,500
	Vanguard Total International Stock Index Fund Admiral	55,743	1,568,708	2,259,243
	Parnassus Core Equity Fund - Institutional Shares	27,204	1,349,439	1,527,227
	Hartford World Bond Fund Class Y	70,497	744,726	705,672
	FPA Crescent Fund Supra Institutional Class	7,369	286,136	317,955
	BlackRock Event Driven Equity Fund Institutional Shares	22,952	229,494	238,699
	BlackRock Strategic Income Opportunities Portfolio Investor A Shares	25,483	258,452	248,969
	Total mutual funds			16,345,218
	Money market and similar funds:			
*	CBNA Daily Trust Sweep		334,802	334,802
	Limited partnership investment funds:			
	Weatherlow Offshore Fund II LTD	1,009	1,168,720	2,529,601
	Drake Capital Offshore Partners, L.P.	750,000	750,000	1,621,411
	Total limited partnership investment funds			4,151,012
	Common Collective Trust:			
	SSGA Real Asset NL Fund	108,778	1,317,515	2,333,939
	Common stock:			
	MetLife		137	10,886
				$ 23,175,857

* These investments are with parties-in-interest.

PENSION PROGRAM FOR EMPLOYEES OF OLEAN GENERAL HOSPITAL

EIN: 16-0743102
Plan Number 001 - Supplementary Information

Schedule H, Line 4j
Schedule of Reportable Transactions for the year ended December 31, 2025

(a) Identity of Party Involved	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value on Transaction Date	(i) Net Gain or (Loss)
Series of transactions in excess of 5% of Plan Assets:						
Community Bank, N.A.	Money Market	$ 2,694,593	$ -	$ 2,694,593	$ 2,694,593	$ -
Community Bank, N.A.	Money Market	$ -	$ 2,802,413	$ 2,802,413	$ 2,802,413	$ -