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
EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 03/01/1997

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)
COMMUNITY HEALTH GROUP

2420 FENTON STREET, STE. 100
CHULA VISTA, CA 91914

2b Employer Identification Number (EIN)
95-3766170

2c Plan Sponsor's telephone number
619-422-0422

2d Business code (see instructions)
524140

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.	10/15/2026	JULIE WOHLSTEIN
	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**	395
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)**	395
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	395
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	395
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4E 4F 4G 4H

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	**(1)**	[X] 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)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
COMMUNITY HEALTH GROUP

D Employer Identification Number (EIN)
95-3766170

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
57-0144607	62049	E3075538	259	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
49968	4012

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

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

SAMAR BREIK ALBIN
41572 VALOR DR
MURRIETA, CA 92562

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13538	1964	FEES PAID	3

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

KINGHORN & COMPANY INSURANCE GROUP

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6516			3

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

ACRIALPS LLC

PO BOX 1788
GRAND RAPIDS, MI 49501

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4624			3

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

SUSIE A ESTRADA

25742 PARK AVE
SAN JUAN CAPISTRANO, CA 92675

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3124	617	FEES	3

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

SAMANTHA JACOBS

5056 PLAZA PROMENADE
SAN DIEGO, CA 92123

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3469			3

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

ANDREA MARIE TIERCE

1199 MADRONE LN
PLACERVILLE, CA 95667

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2271	586	FEES PAID	3

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

CRAIG F KIGHORN

PO BOX 211236
CHULA VISTA, CA 91921

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2834			3

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

STEPHEN WHITE

8619 WEST PAYETTE CT
KENNEWICK, WA 99336

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2595			3

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

KINGHORN & ASSOCIATES INS & FINANCI

PO BOX 211236
CHULA VISTA, CA 91921

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2414			3

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

SCOTT C CASTEEL

1450 W JAMES WAY
ANAHEIM, CA 92801

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1844			3

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

RALPH F REA JR

84 VIA BARCELONA
RANCHO SANTA MARGARITA, CA 92688

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1662			3

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

LORI LAINE

34676 CONADRIA AVENUE
YUCAIPA, CA 92399

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
947	450	FEES	3

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

LUIS RAFAEL VALLE
2354 CHATKA LN
SAN BERNARDINO, CA 92410

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1058	128	FEES	3

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

PJNP INC
310 S TWIN OAKS VLY RD # 107-2
SAN MARCOS, CA 92078

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1150			3

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

JULIE ANNE KINGHORN
PO BOX 211236
CHULA VISTA, CA 91921

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
816			3

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

ERIC CHRISTOPHER LAINE
34676 CONADRIA AVENUE
YUCAIPA, CA 92399

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
492	202	FEES	3

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

ROGER STUART KENCHEL
2588 EL CAMINO REAL STE F188
CARLSBAD, CA 92008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
179			3

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

JOHN D EVANGELISTA
186 LAS FLORES
ALISO VIEJO, CA 92656

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
83	63	FEES	3

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

DEBORAH RUSH KIMMONS
37291 BOSLEY ST
INDIO, CA 92203

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
81			3

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

BARBARA ELLEN SMITH
4040 EAST PIEDMONT DR. SPC 228
HIGHLAND, CA 92346

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

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

CHELSEA L WARE LLC
11425 PERUGINO DRIVE
LAS VEGAS, NV 89138

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
45			3

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

RAYMOND KWOCKMAN GONG
1907 COLUMBIA ST APT 501
SAN DIEGO, CA 92108

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
41			3

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

MIKE MCCORMICK

7 MONSERRAT PL
FOOTHILL RANCH, CA 92610

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
39			3

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

MARTHA ANGELICA HILL ESTRADA

2991 ESCALA CIR
SAN DIEGO, CA 92108

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
30			3

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

MICHAEL MINNEY

PO BOX 365
POWAY, CA 92074

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
26	2	FEES	3

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

LUKE A SALERNO

3985 CARMEL BROOKS WAY
SAN DIEGO, CA 92130

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
16			3

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

COURTNEY MCFARLAND

8321 W SAHARA AVE APT 2128
LAS VEGAS, NV 89117

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

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

SUSAN GOLD STOKES

104 MISTY HOLLOW WAY
HUNTINGTON BEACH, CA 92647

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4			3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	384114
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2025** **This Form is Open to Public Inspection.**

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

A Name of plan
EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
COMMUNITY HEALTH GROUP

D Employer Identification Number (EIN)
95-3766170

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CENTRIX BENEFIT ADMINISTRATORS, INC

P.O. BOX 212199
CHULA VISTA, CA 77052-3382

77-0523382

(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?
15 12 50	THIRD PARTY	397958	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KINGHORN & ASSOCIATES

817 BOW SPRIT ROAD
SUITE 200
CHULA VISTA, CA 91914

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 53	NONE	135184	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CERPASSRX

73-1700173

(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?
49	PBM	36189	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

AMERICAN HEALTH

7400 W CAMPUS ROAD F510
NEW ALBANY, OH 43054

(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?
49	UR, PRE-CERT, AND TAN	19200	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LLME

33-0690020

(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?
10	CPA	12228	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
COMMUNITY HEALTH GROUP

D Employer Identification Number (EIN)
95-3766170

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)	650900	671718
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	382250	0
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	0	0

		(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	1033150	671718
Liabilities			
1g Benefit claims payable	1g	1243051	1599939
1h Operating payables	1h	0	4945
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	1243051	1604884
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	-209901	-933166

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)	6746819	
(B) Participants	2a(1)(B)	957983	
(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)		7704802
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		7704802
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4845578	
(2) To insurance carriers for the provision of benefits	2e(2)	2525360	
(3) Other	2e(3)	107500	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		7478438
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)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	949629	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		949629
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		8428067
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-723265
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: LAVINE, LOFGREN, MORRIS ENGELBERG **(2)** EIN: 33-0690020

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		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

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

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

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

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

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

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

INDEPENDENT AUDITORS' REPORT AND FINANCIAL STATEMENTS

For the Year Ended December 31, 2025

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

Table of Contents

INDEPENDENT AUDITORS' REPORT ..... 1 – 2

FINANCIAL STATEMENTS:

Statements of Net Assets Available for Benefits
As of December 31, 2025 and 2024 3

Statement of Changes in Net Assets Available for Benefits
For the Year Ended December 31, 2025 4

Statements of Benefit Obligations
As of December 31, 2025 and 2024 5

Statement of Changes in Benefit Obligations
For the Year Ended December 31, 2025 6

Notes to Financial Statements ..... 7 – 10

LAVINE, LOFGREN, MORRIS & ENGELBERG, LLP
CERTIFIED PUBLIC ACCOUNTANTS

4180 LA JOLLA VILLAGE DRIVE SUITE 300 LA JOLLA CALIFORNIA 92037

PHONE (858) 455-1200
FAX (858) 455-0898
WEB SITE www.llme.com

An Independent Member of BKR International

INDEPENDENT AUDITORS' REPORT

To the Plan Administrator
Employee Benefit Trust for Community Health Group
Chula Vista, California

Opinion

We have audited the accompanying financial statements of Employee Benefit Trust for Community Health Group (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 and benefit obligations as of December 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and changes in benefit obligations for the year ended December 31, 2025, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of Employee Benefit Trust for Community Health Group as of December 31, 2025 and 2024, and the changes in its net assets available for benefits and changes in benefit obligations for the year ended December 31, 2025, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Employee Benefit Trust for Community Health Group and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that 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

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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 Employee Benefit Trust for Community Health Group's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 generally accepted auditing standards, 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 Employee Benefit Trust for Community Health Group'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 Employee Benefit Trust for Community Health Group'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.

Emphasis of Matter — Uncertainty Regarding VEBA Trust Tax-Exempt Status

As discussed in Note 5, the Voluntary Employees' Beneficiary Association ("VEBA") Trust under which the Plan operates is believed to have received a tax-exempt determination letter, but management is unable to locate the tax-exempt letter in order to confirm that such tax-exempt status is valid. As discussed in Note 5, this uncertainty could affect the VEBA Trust's current and future tax position and the Plan's financial statements amounts and disclosures. Our opinion is not modified with respect to this matter.

Squire, Sanders & Dempsey, LLP

La Jolla, California
October 15, 2026

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

Statements of Net Assets Available for Benefits
As of December 31, 2025 and 2024

	2025	2024
ASSETS		
Cash	$ -	$ 382,250
Stop-loss insurance reimbursement receivable	671,718	650,900
Total assets	671,718	1,033,150
LIABILITIES - accrued liabilities	4,945	-
NET ASSETS AVAILABLE FOR BENEFITS	$ 666,773	$ 1,033,150

See accompanying notes to financial statements.

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

Statement of Changes in Net Assets Available for Benefits
For the Year Ended December 31, 2025

Additions to net assets attributed to:	
Contributions:	
Employer	$ 6,746,819
Participants	957,983
Total contributions	7,704,802
Total additions	7,704,802
Deductions from net assets attributed to:	
Health and pharmacy claims, net	4,488,690
Insurance premiums for the provision of benefits	2,525,360
Flex plan payments	107,500
Administrative and other expenses	949,629
Total deductions	8,071,179
Net decrease	(366,377)
Net assets available for benefits:	
Beginning of year	1,033,150
End of year	$ 666,773

See accompanying notes to financial statements.

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

Statements of Benefit Obligations
As of December 31, 2025 and 2024

	2025	2024
Net assets available for benefits	$ 666,773	$ 1,033,150
Benefit obligations:		
Health claims payable and claims incurred but not reported	1,599,939	1,243,051
Excess (deficit) of net assets available for benefits over benefit obligations	$ (933,166)	$ (209,901)

See accompanying notes to financial statements.

EMPLOYEE BENEFIT TRUST FOR COMMUNITY HEALTH GROUP

Statement of Changes in Benefit Obligations
For the Year Ended December 31, 2025

Obligations for current benefit coverage at present value of claims incurred but not reported

Balance at beginning of the year	$ 1,243,051
Claims reported and approved for payment	4,953,078
Claims paid, net	(4,596,190)
Total benefit obligations at end of the year	$ 1,599,939

See accompanying notes to financial statements.

NOTE 1. DESCRIPTION OF PLAN

The following description of the Employee Benefit Trust for Community Health Group (the "Plan") provides only general information. Participants should refer to the Plan Document for a more complete description of the Plan's provisions.

General

The Plan is a health and welfare benefit plan established by Community Health Group (the "Company") on March 1, 1997 to provide health, disability, and death benefits to full-time employees and to their beneficiaries and covered dependents. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Chief Executive Officer, who is also the Plan's authorized representative, is responsible for oversight of the Plan. Administrative services are provided by Centrix Benefit Administrators, Inc.

Benefits

The Plan provides health benefits (medical, dental, vision, and pharmacy) for eligible employees of the Company and their beneficiaries/dependents. These health benefits are self-insured. See "Stop-Loss Insurance Policy" later in this section. All covered employees also receive term life insurance benefits equal to two times their annual salary (up to a maximum of $300,000 face value) and an equivalent amount for accidental death and dismemberment insurance. In addition, the Plan purchases insurance for long-term disability and long-term care benefits upon election by the employees.

In accordance with the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), the Plan provides for continuation of benefits for certain terminated employees up to eighteen months and certain dependents for a period of up to thirty-six months depending upon eligibility. The cost of these benefits is paid by the terminated employees or their dependents. The Plan also provides the sponsorship of voluntary and supplemental benefits.

The Plan includes a cafeteria arrangement maintained pursuant to Section 125 of the Internal Revenue Code ("IRC") in which employees may elect to reduce their taxable salary in favor of purchasing nontaxable benefits including reimbursements of medical expenses and dependent childcare expenses.

Eligibility

Those employees who are employed a minimum of thirty hours per week are eligible to participate on the first day of the month following thirty days of service. An employee will become a participant in the Plan on the first day of the month immediately following the date the employee satisfies the eligibility conditions.

Participant Contributions

In addition to deductibles and co-payments, participants contribute specified amounts based on applicable monthly premiums for their respective benefit elections. Participants pay the full cost of voluntary supplemental, dependent life insurance, and supplemental ancillary benefit programs based on elections.

The Plan also receives contributions from employees which are deducted per a salary reduction arrangement as provided by Sections 125 and 129 of the IRC.

NOTE 1. DESCRIPTION OF PLAN (Continued)

Employer Contributions

The Company provides funds to the Plan administrator to pay health claims, insurance premiums, and administrative fees. The Company makes contributions to the Plan as needed to fund claims in excess of participant contributions. Any deficiency resulting from benefit obligations in excess of Plan net assets available for benefits is funded by the Company on a pay-as-you-go basis.

Benefit Obligations

Plan liabilities for estimated health claims incurred but not reported are estimated by the Plan primarily based on health benefit claim payment registers and claims reports provided by the Plan administrator and are reported at their present value. These amounts are paid by the Plan only if claims are submitted and approved for payment within 180 days after the Plan year. Health claims payable and claims incurred but not reported totaled $1,599,939 and $1,243,051 as of December 31, 2025 and 2024, respectively.

Stop-Loss Insurance Policy

The Company has obtained reinsurance coverage from a third-party carrier for medical claims which generally exceed $150,000 per participant per year in 2025 and 2024 with no maximum limit. As of December 31, 2025 and 2024, there were $671,718 and $650,900, respectively, in receivables for unpaid claim reimbursements based upon the stop-loss coverage limits. For the year ended December 31, 2025, $671,718 has been netted against health and pharmacy claims in the accompanying statement of changes in net assets available for benefits.

Administration Expenses

The Plan has an agreement with a third-party administrator to provide administrative services, claims adjudication, COBRA administration and other services. In addition, the Plan pays fees for services provided through other contracts. Administrative expenses were $868,629 for the year ended December 31, 2025.

Plan Termination

Although it has not expressed any intent to do so, the Company has the right to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits of or on account of the participants. No assets of the Plan may revert back to the Company or be used for a purpose other than the exclusive benefits of the Plan's participants.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the Plan are prepared using the accrual method of accounting in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). Employee and employer contributions are recognized in the period that contributions are due.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires the Plan administrator to make estimates and assumptions that may affect the reported amounts of assets, benefit obligations, and changes therein, claims incurred but not reported, claims payable, liabilities and disclosure of contingent assets and liabilities. Accordingly, actual results may differ from those estimates.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Payment of Benefits

Premiums are expensed when paid by the Company in the accompanying statement of changes in net assets available for benefits.

Claim payments are recorded when paid by the third-party claims processor. Amounts due to claims processors that have not been reimbursed by the Plan are recorded as payable to claims administrators. As of December 31, 2025 and 2024, there are no payables to claims administrators.

Subsequent Events

The Plan has evaluated subsequent events through the date of the independent auditors' report, which is the date these financial statements were available to be issued.

NOTE 3. CONTRACTS WITH INSURANCE COMPANIES FOR STOP-LOSS REIMBURSEMENTS

The Plan has contracts with insurance companies, whereby the insurance companies pay claims exceeding a predetermined deductible threshold, which are then used to reduce the Plan's payments. Premiums paid by the Plan for such insurance contracts are included in the accompanying statements of changes in benefit obligations and net assets available for benefits under insurance premiums for the provision of benefits.

NOTE 4. RELATED PARTIES AND PARTY IN-INTEREST TRANSACTIONS

The Plan has entered into an administrative contract with Centrix Benefit Administrators, a third-party administrator, to provide administrative services, to collect contributions, transmit payments to the various insurers and provide claims and COBRA administration. The Plan also incurs other administrative fees with parties in-interest for purposes of operating the Plan. Fees incurred by the Plan for these services are included in the accompanying statement of changes in benefit obligations and net assets available for benefits.

NOTE 5. INCOME TAX STATUS

Plan management believes that the Voluntary Employees' Beneficiary Association ("VEBA") Trust established under the Plan to hold the Plan's assets qualifies pursuant to Section 501(c)(9) of the IRC and, as such, is exempt from taxation. Plan management believes the Plan is also exempt from California income taxes and is exempt under Section 23701(i). Plan management believes the VEBA Trust continues to meet the applicable requirements for exemption, including that substantially all operations are in furtherance of providing permissible health and welfare benefits to members and their dependents or designated beneficiaries and that no part of the VEBA Trust's net earnings inures to the benefit of any private shareholder or individual other than through payment of such benefits. As such, no provision for income taxes has been recorded.

NOTE 5. INCOME TAX STATUS (Continued)

Plan management is unable to locate an IRS determination letter specifically confirming the VEBA Trust's current tax-exempt status under IRC Section 501(c)(9). In addition, the VEBA Trust's qualification for exemption is subject to additional statutory requirements, including nondiscrimination requirements applicable to certain plans funded through a Section 501(c)(9) organization. Required nondiscrimination testing has not been completed for the 2025 Plan year as of the date the accompanying financial statements were issued. Because satisfaction of the nondiscrimination requirements is a condition to exemption for a Section 501(c)(9) organization that is part of a plan, completion of this testing is relevant to Plan management's evaluation of the VEBA Trust's tax-exempt status.

U.S. GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) for any uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Notwithstanding the absence of a current IRS determination letter and the fact that nondiscrimination testing has not yet been completed for the 2025 Plan year, Plan management believes the VEBA Trust continues to operate in compliance with the applicable requirements for tax exemption and has evaluated its tax positions in accordance with ASC 740, *Accounting for Income Taxes*, including the tax position that the VEBA Trust is not subject to federal income tax. Under ASC 740, tax benefits are recognized only if it is more likely than not that the related tax position will be sustained upon examination based on its technical merits. Based on this evaluation, no material liabilities for income taxes are recognized in the accompanying financial statements as of December 31, 2025. Plan management will continue to monitor the VEBA Trust's operations for ongoing compliance with the applicable requirements for exemption and for any activities that could give rise to taxable income.

NOTE 6. CONCENTRATIONS

The Plan maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Plan has not experienced any losses in such accounts.

NOTE 7. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 at December 31, 2025 and 2024:

	2025	2024
Net assets available for benefits per the financial statements	$ 666,773	$ 1,033,150
Health claims payable and claims incurred but not reported	(1,599,939)	(1,243,051)
Net assets available for benefits (deficit) per the Form 5500	$ (933,166)	$ (209,901)

The following is a reconciliation of the net decrease in net assets available for benefits per the financial statements to the net loss per the Form 5500 for the year ended December 31, 2025:

Net decrease in net assets available for benefits per the financial statements	$ (366,377)
Change in health claims payable and claims incurred but not reported	(356,888)
Net loss per the Form 5500	$ (723,265)