

| | | |
|---|---|---|
| <p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-small;">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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p> |
|---|---|---|

Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

| | |
|---|--|
| <p>1a Name of plan <u>ELEVATE CARE, INC. 401(K) PLAN</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>002</u></p> |
| <p>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) <u>ELEVATE CARE, INC.</u></p> <p><u>8150 CENTRAL PARK AVENUE</u> <u>SKOKIE, IL 60076</u></p> | <p>1c Effective date of plan <u>01/01/2000</u></p> <p>2b Employer Identification Number (EIN) <u>36-3223168</u></p> <p>2c Plan Sponsor's telephone number <u>184-767-4545</u></p> <p>2d Business code (see instructions) <u>541600</u></p> |

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. | 07/20/2025 | JEFF GOLDSTEIN |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 07/20/2025 | JEFF GOLDSTEIN |
| | 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 <input checked="" type="checkbox"/> 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 | | | |
| c Plan Name | | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | | 5 | 2531 |
| 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) | 2381 |
| a(2) Total number of active participants at the end of the plan year | | 6a(2) | 1725 |
| b Retired or separated participants receiving benefits..... | | 6b | 23 |
| c Other retired or separated participants entitled to future benefits | | 6c | 149 |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | | 6d | 1897 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | | 6e | 1 |
| f Total. Add lines 6d and 6e | | 6f | 1898 |
| 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) | 379 |
| 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) | 344 |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | | 6h | 60 |
| 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 Characteristics Codes in the instructions:
 2E 2F 2H 2J 2K 2T 3D 3H

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

| | | | |
|---|--|---|--|
| 9a Plan funding arrangement (check all that apply) | | 9b Plan benefit arrangement (check all that apply) | |
| (1) <input type="checkbox"/> Insurance | | (1) <input type="checkbox"/> Insurance | |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | |
| (3) <input checked="" type="checkbox"/> Trust | | (3) <input checked="" type="checkbox"/> Trust | |
| (4) <input type="checkbox"/> General assets of the sponsor | | (4) <input type="checkbox"/> 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 | | b General Schedules | |
| (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) | | (1) <input checked="" type="checkbox"/> H (Financial Information) | |
| (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | | (2) <input type="checkbox"/> I (Financial Information – Small Plan) | |
| (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | | (3) <input type="checkbox"/> A (Insurance Information) – Number Attached _____ | |
| (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ | | (4) <input checked="" type="checkbox"/> C (Service Provider Information) | |
| (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information) | | (5) <input type="checkbox"/> D (DFE/Participating Plan Information) | |
| | | (6) <input type="checkbox"/> 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Service Provider 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. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection. |
|--|--|---|

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

| | | |
|--|--|------------|
| A Name of plan ELEVATE CARE, INC. 401(K) PLAN | B Three-digit plan number (PN) ▶ | 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 ELEVATE CARE, INC. | D Employer Identification Number (EIN) 36-3223168 | |

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)

THE WEISS GROUP, INC.

400 SKOKIE BLVD
SUITE 415
NORTHBROOK, IL 60062

| (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 15 64 37 | NONE | 95746 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

LPL FINANCIAL

4707 EXECUTIVE DRIVE
SAN DIEGO, CA 92121

| (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 33 | NONE | 38005 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

OSTROW REISIN BERK & ABRAMS, LTD.

455 NORTH CITYFRONT PLAZA DRIVE
SUITE 1500
CHICAGO, IL 60611

| (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 | NONE | 25000 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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)

MID ATLANTIC CAPITAL CORP

1251 WATERFRONT PLACE, SUITE 525
PITTSBURGH, PA 15222-4236

| (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? |
|------------------------|---|--|--|--|---|--|
| 19 | NONE | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

(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 <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

(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 <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | 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 2024 This Form is Open to Public Inspection |
|--|--|---|

| | |
|--|--|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 | |
| A Name of plan ELEVATE CARE, INC. 401(K) PLAN | B Three-digit plan number (PN) ▶ 002 |
| C Plan sponsor's name as shown on line 2a of Form 5500 ELEVATE CARE, INC. | D Employer Identification Number (EIN) 36-3223168 |

| | |
|---------------|--------------------------------------|
| 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.

| | | (a) Beginning of Year | (b) End of Year |
|--|-----------------|-----------------------|-----------------|
| Assets | | | |
| a Total noninterest-bearing cash | 1a | | |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 6633 | 3141 |
| (2) Participant contributions | 1b(2) | 19381 | 0 |
| (3) Other | 1b(3) | 1138 | 3558 |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 60081 | 18561 |
| (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) | 157847 | 333313 |
| (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) | 7197371 | 7718806 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | | |
| (15) Other | 1c(15) | | |

| 1d Employer-related investments: | | (a) Beginning of Year | (b) End of Year |
|--|--------------|-----------------------|-----------------|
| (1) Employer securities..... | 1d(1) | | |
| (2) Employer real property..... | 1d(2) | | |
| e Buildings and other property used in plan operation..... | 1e | | |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 7442451 | 8077379 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | 150 | 18968 |
| h Operating payables..... | 1h | | |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 59930 | 19450 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 60080 | 38418 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 7382371 | 8038961 |

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) | 111734 | |
| (B) Participants..... | 2a(1)(B) | 1084003 | |
| (C) Others (including rollovers)..... | 2a(1)(C) | 108611 | |
| (2) Noncash contributions..... | 2a(2) | 0 | |
| (3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2) | 2a(3) | | 1304348 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 31082 | |
| (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) | 18432 | |
| (F) Other..... | 2b(1)(F) | | |
| (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | | 49514 |
| (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) | 46670 | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 46670 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | 53101 | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | | |

| | | (a) Amount | (b) Total |
|---|---------------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts | 2b(6) | | |
| (7) Net investment gain (loss) from pooled separate accounts | 2b(7) | | |
| (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) | | 495804 |
| c Other income | 2c | | 270 |
| d Total income. Add all income amounts in column (b) and enter total..... | 2d | | 1949707 |

Expenses

| | | | |
|--|---------------|---------|---------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers..... | 2e(1) | 1081408 | |
| (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) | | 1081408 |
| f Corrective distributions (see instructions) | 2f | | |
| g Certain deemed distributions of participant loans (see instructions)..... | 2g | | 52774 |
| h Interest expense..... | 2h | | |
| i Administrative expenses: | | | |
| (1) Salaries and allowances | 2i(1) | | |
| (2) Contract administrator fees | 2i(2) | 80528 | |
| (3) Recordkeeping fees | 2i(3) | 11769 | |
| (4) IQPA audit fees | 2i(4) | 25000 | |
| (5) Investment advisory and investment management fees | 2i(5) | 38005 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | 3448 | |
| (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) | 185 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 158935 |
| j Total expenses. Add all expense amounts in column (b) and enter total..... | 2j | | 1293117 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|--------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 656590 |
| l Transfers of assets: | | | |
| (1) To this plan..... | 2l(1) | | |
| (2) From this plan | 2l(2) | | |

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **OSTROW REISIN BERK & ABRAMS, LTD.**

(2) EIN: **36-2938874**

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.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 7451 |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| e Was this plan covered by a fidelity bond? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 500000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | |
| 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.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| l Has the plan failed to provide any benefit when due under the plan? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> | |

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

| | | |
|--|---|--|
| SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | 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 2024 This Form is Open to Public Inspection. |
|--|---|--|

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

| | | |
|--|--|------------|
| A Name of plan <u>ELEVATE CARE, INC. 401(K) PLAN</u> | B Three-digit plan number (PN) | <u>002</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>ELEVATE CARE, INC.</u> | D Employer Identification Number (EIN) <u>36-3223168</u> | |

| | |
|---------------|----------------------|
| 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 | | 0 |
|---|--|---|

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): 27-3169253

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

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

| | |
|---|--|
| 3 | |
|---|--|

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

| | | |
|---|-----------|--|
| 6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) | 6a | |
| b Enter the amount contributed by the employer to the plan for this plan year | 6b | |
| c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)..... | 6c | |

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

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

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

| | |
|-----------------|-------------------|
| Part III | Amendments |
|-----------------|-------------------|

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

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

| | | |
|---|------------|--|
| a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment)..... | 14a | |
| b The plan year immediately preceding the current plan year. <input type="checkbox"/> 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. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)..... | 14c | |

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

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

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

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

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

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

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

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

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

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

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

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

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation. _____

Part VII IRS Compliance Questions

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

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).
 Design-based safe harbor method
 "Prior year" ADP test
 "Current year" ADP test
 N/A

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 06 / 30 / 2020 (MM/DD/YYYY) and the Opinion Letter serial number Q702751A.

ELEVATE CARE, INC. 401(k) PLAN

**FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION**

DECEMBER 31, 2024 AND 2023

ELEVATE CARE, INC. 401(k) PLAN

DECEMBER 31, 2024 AND 2023

CONTENTS

| | Page |
|--|-------|
| Independent auditors' report | 1-4 |
| Financial statements: | |
| Statements of net assets available for benefits | 5 |
| Statement of changes in net assets available for benefits | 6 |
| Notes to financial statements | 7-17 |
| Supplemental schedules required by the Department of Labor: | |
| Schedule of assets (held at end of year) | 18-19 |
| Schedule of delinquent participant contributions | 20-21 |



Independent Auditors' Report

Plan Administrator
Elevate Care, Inc. 401(k) Plan

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

We have performed audits of the accompanying financial statements of Elevate Care, Inc. 401(k) Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) [ERISA Section 103(a)(3)(C) audit]. The financial statements comprise the statements of net assets available for benefits as of December 31, 2024 and 2023, and the related statement of changes in net assets available for benefits for the year ended December 31, 2024, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of Elevate Care, Inc. 401(k) Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audits need not extend to any statements or information related to assets held for investment of the plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from a qualified institution as of December 31, 2024 and 2023, and for the year ended December 31, 2024, stating that the certified investment information, as described in Note 4 to the financial statements, is complete and accurate.

Opinion

In our opinion, based on our audits and on the procedures performed as described in the Auditors' Responsibilities for the Audit of the Financial Statements section—

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 Elevate Care, Inc. 401(k) Plan and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Elevate Care, Inc. 401(k) Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditors' Responsibilities for the Audit of the Financial Statements

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an 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 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 Elevate Care, Inc. 401(k) 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 Elevate Care, Inc. 401(k) Plan's ability to continue as a going concern for a reasonable period of time.

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

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

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

Other Matters - Supplemental Schedules Required by ERISA

The supplemental schedule of assets (held at end of year) as of December 31, 2024 and schedule of delinquent participant contributions for the year ended December 31, 2024, are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

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

In our opinion—

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

Ostrow Reisin Berk & Abrams, Ltd.

July 15, 2025

ELEVATE CARE, INC. 401(k) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

| December 31, | 2024 | 2023 |
|--|---------------------|---------------------|
| Assets: | | |
| Investments | \$ 7,737,367 | \$ 7,257,452 |
| Receivables: | | |
| Employer contributions | 3,141 | 6,633 |
| Participant contributions | | 19,381 |
| Notes receivable from participants | 333,313 | 157,847 |
| Other receivables | 3,558 | 1,138 |
| Total receivables | 340,012 | 184,999 |
| Total assets | 8,077,379 | 7,442,451 |
| Liabilities: | | |
| Accounts payable | 38,418 | 60,080 |
| Refunds of excess contributions | 86,534 | 111,825 |
| Total liabilities | 124,952 | 171,905 |
| Net assets available for benefits | \$ 7,952,427 | \$ 7,270,546 |

See notes to financial statements.

ELEVATE CARE, INC. 401(k) PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

| Year ended December 31, 2024 | |
|--|--------------|
| Additions to net assets attributed to: | |
| Investment income: | |
| Net appreciation in fair value of investments | \$ 548,905 |
| Interest and dividend income | 78,023 |
| Total investment income | 626,928 |
| Interest on notes receivable from participants | 18,432 |
| Contributions: | |
| Participants | 997,469 |
| Employer | 111,734 |
| Rollover | 108,611 |
| Total contributions | 1,217,814 |
| Total additions | 1,863,174 |
| Deductions from net assets attributed to: | |
| Benefits paid to participants | 1,022,358 |
| Administrative expenses | 158,935 |
| Total deductions | 1,181,293 |
| Net increase | 681,881 |
| Net assets available for benefits: | |
| Beginning of year | 7,270,546 |
| End of year | \$ 7,952,427 |

See notes to financial statements.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

1. Description of the Plan

The following description of Elevate Care, Inc. 401(k) Plan (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

General:

The Plan is a defined-contribution plan that was adopted on January 1, 2000, covering all full-time employees, excluding union employees, unless explicitly stated that they can participate in their collective bargaining agreement and employees who are nonresident aliens, of Elevate Care Riverwoods, LLC, Elevate Care Northbrook, LLC, Elevate Care Niles, LLC, Elevate Care Chicago North, LLC, Elevate Care Waukegan, Elevate Care, Inc., Elevate Care North Branch, LLC, Elevate Care Country Club Hills, LLC, The Terrace at Hialeah, Elevate Care Abington, Elevate Care Consulting, LLC, Elevate Care South Holland, LLC, Elevate Care Windsor Park, LLC and Elevate Care Palos Heights, LLC (collectively, the Company), who have attained the age of 21 or older and have completed at least one hour of service.

Effective January 1, 2023, Elevate Care Palos Heights, LLC, Elevate Care South Holland, LLC and Elevate Care Consulting, LLC became participating employers in the Plan. Employees were eligible to participate in the Plan immediately.

Effective April 30, 2023, Elevate Care Irving Park, LLC is no longer in the Plan. The participants for this entity are no longer employees of the Company and are no longer eligible to participate in the Plan. The participants' assets will remain in the Plan until they are distributed.

Effective July 1, 2024, Elevate Care Windsor Park, LLC became a participating employer in the Plan. Employees were eligible to participate in the Plan immediately.

Effective May 1, 2024, The Terrace of Boca Raton d/b/a Menorah House, The Terrace of Delray Beach, LLC and The Terrace of Lake Worth d/b/a Elevate Care Lake Worth are no longer in the Plan. The participants for these entities are no longer employees of the Company and are no longer eligible to participate in the Plan. The participants' assets will remain in the Plan until they are distributed.

Employees may enter the Plan each year on January 1 and July 1.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

1. Description of the Plan (continued)

Contributions:

Each year, participants may contribute up to 100% of eligible compensation through pre-tax or Roth deferrals. Participants who have attained the age of 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined-benefit or defined-contribution plans. Contributions are limited in accordance with Internal Revenue Service (IRS) regulations. The Plan permits discretionary matching contributions by the Company. For the year ended December 31, 2024, the Company contributed 10% of each participant's deferrals not to exceed 15% of total compensation. All participants are eligible for matching contributions.

In addition, the Company may make annual discretionary profit-sharing contributions. Employees must have completed one year of service and be employed on the last day of the year to be eligible for such discretionary contributions.

Participant accounts:

Each participant directs their individual investments including their share of allocated Company contributions into various investment options offered by the Plan. Each participant's account is credited with contributions, appreciation (depreciation) in fair value of investments and interest and dividend income. Allocations are based on participant earnings or account balances as defined by the Plan.

Vesting:

Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in employer contributions, plus actual earnings thereon, is based on years of credited service. A participant is 20% vested after two years of credited service and an additional 20% vested after each additional year of credited service.

Participant loans:

Loans are available to Plan participants at Prime (7.50% and 8.50% as of December 31, 2024 and 2023, respectively) plus 1.00% at the time of issuance. The minimum loan is \$1,000 and the maximum amount is equal to the lesser of \$50,000 reduced by the highest outstanding loan balance in the participant's account during the prior twelve-month period or 50% of their vested account balance. Principal and interest is paid ratably through payroll deductions. All loans must be repaid over a five-year period, unless the loan is for the purchase of a principal residence, for which the term of the loan may be as long as 30 years. Loan defaults are treated as distributions. The loans are secured by the balance in the participant's account.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

1. Description of the Plan (continued)

Refunds of excess contributions:

Amounts payable to participants for contributions in excess of amounts allowed by the IRS are recorded as a liability with a corresponding reduction to contributions. The excess contributions as of December 31, 2024 and 2023 totaling \$86,534 and \$111,825, respectively, were distributed by the Plan to the applicable participants within the allowable time frame as required by ERISA.

Payment of benefits:

Upon retirement, death or disability, a participant becomes 100% vested in his or her account. Upon termination of service, a participant is entitled to receive only the vested percentage of his or her account balance. If a participant's vested balance does not exceed \$5,000, then the vested balance may only be distributed in a single lump-sum payment. Any balance that exceeds \$5,000 may be received as a single lump-sum payment or as partial withdrawals. Payments may be received as a cash distribution or rolled directly into an eligible retirement plan as an eligible rollover distribution.

The Plan also allows in-service withdrawals from a participant's vested account balance for hardship withdrawals or upon attaining the age of 65.

Forfeitures:

If a participant terminates employment and is less than 100% vested in the employer account, then the participant will forfeit the nonvested portion of the employer account. Forfeitures are retained in the Plan and will first be used to pay administrative expenses. Any remaining amounts will be used to reduce future employer contributions payable under the Plan. Forfeitures arising during the year ended December 31, 2024 totaled \$45,507. During the year ended December 31, 2024, \$4,669 was used from forfeited nonvested accounts to reduce employer contributions and \$40,228 was used from forfeited nonvested accounts to pay Plan expenses.

2. Summary of significant accounting policies

Basis of accounting:

The accompanying financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

2. Summary of significant accounting policies (continued)

Investment valuation and income recognition:

The Plan's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 5 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Interest is recognized on the accrual basis. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Notes receivable from participants:

As described in Note 1, the Plan allows participants to borrow against their vested account balances and the loans are secured by the participants' account balances. Participant loans are reported at their unpaid principal balance plus any accrued but unpaid interest.

Contributions:

Participants' contributions are recognized by the Plan when withheld from the participants' paychecks by the Company.

Administrative expenses:

All administrative costs, charges and expenses are paid by the Plan to the extent not paid by the Company.

Expense offset arrangements:

Fees incurred by the Plan for investment management services are included in net appreciation (depreciation) in fair value of investments, as they are paid through revenue sharing, rather than a direct payment.

Payment of benefits:

Benefits are recorded when paid.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

2. Summary of significant accounting policies (continued)

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 reported amounts of net assets available for benefits as of the end of the Plan year and the reported amounts of changes in net assets available for benefits during the period. Accordingly, actual results could differ from those estimates.

Subsequent events:

The Plan Administrator has reviewed and evaluated subsequent events through July 15, 2025, the date the financial statements were available to be issued.

3. Risks and uncertainties

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

4. Investments (prepared and certified by Mid Atlantic Trust Company d/b/a American Trust Company (the Trustee))

The Plan Administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the following information related to participant-directed investments included in these financial statements and supplemental schedule of assets (held at end of year) was obtained from data that has been prepared and certified to as complete and accurate by the Trustee as of December 31, 2024 and 2023.

| December 31, | 2024 | 2023 |
|------------------------------|--------------|--------------|
| Mutual funds | \$ 4,395,889 | \$ 3,206,512 |
| Common collective trust fund | 3,322,917 | 3,990,859 |
| Interest-bearing cash | 18,561 | 60,081 |
| Total | \$ 7,737,367 | \$ 7,257,452 |

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

4. Investments (prepared and certified by Mid Atlantic Trust Company d/b/a American Trust Company (the Trustee)) (continued)

Interest rates on outstanding loans ranged from 4.25% to 9.50% at December 31, 2024 and 2023.

The Trustee certified to the completeness and accuracy of interest and dividend income of \$78,023, interest on notes receivable from participants of \$18,432, and net appreciation in fair value of investments of \$548,905 for the year ended December 31, 2024.

Notes receivable from participants of \$333,313 and \$157,847 are also certified by the Trustee at December 31, 2024 and 2023, respectively.

5. Fair value measurements

There are three levels of inputs used to measure fair value. The definition of each input is described below:

| | |
|---------|---|
| Level 1 | Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access. |
|---------|---|

| | |
|---------|--|
| Level 2 | Inputs to the valuation methodology include: <ul style="list-style-type: none">• quoted prices for similar assets or liabilities in active markets;• quoted prices for identical or similar assets or liabilities in inactive markets;• inputs other than quoted prices that are observable for the asset or liability;• inputs that are derived principally from or corroborated by observable market data by correlation or other means. <p>If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.</p> |
|---------|--|

| | |
|---------|---|
| Level 3 | Inputs that are unobservable inputs for the asset or liability. |
|---------|---|

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

5. Fair value measurements (continued)

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

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023.

| | |
|-------------------------------|---|
| Mutual funds: | Valued at the market value of shares held by the Plan at year-end. |
| Interest-bearing cash: | Valued at cost which approximates fair value. |
| Common collective trust fund: | Valued at the net asset value (NAV) of units held by the Plan at year-end. NAV is determined by the custodian of the fund and is based upon the fair value of the underlying assets held by the fund. NAV is used as a practical expedient to estimate fair value. There are no participant redemption restrictions for these investments; the redemption notice period is applicable only to the Plan. |

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan Administrator believes that the Plan's valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

5. Fair value measurements (continued)

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023. Classification within the fair value hierarchy table is based on the lowest level of any input that is significant to the fair value measurement.

Investments at fair value as of December 31, 2024:

| December 31, 2024 | Level 1 | Total |
|---|---------------------|---------------------|
| Mutual funds | \$ 4,395,889 | \$ 4,395,889 |
| Interest-bearing cash* | | 18,561 |
| Common collective trust fund measured at NAV** | | 3,322,917 |
| Total investments at fair value | \$ 4,395,889 | \$ 7,737,367 |

Investments at fair value as of December 31, 2023:

| December 31, 2023 | Level 1 | Total |
|---|---------------------|---------------------|
| Mutual funds | \$ 3,206,512 | \$ 3,206,512 |
| Interest-bearing cash* | | 60,081 |
| Common collective trust fund measured at NAV** | | 3,990,859 |
| Total investments at fair value | \$ 3,206,512 | \$ 7,257,452 |

*Valued at cost which approximates fair value.

**Certain investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in these tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

5. Fair value measurements (continued)

The following table summarizes investments for which fair value is measured using the NAV per share practical expedient as of December 31, 2024 and 2023:

| Investment | 2024 | 2023 | Unfunded commitment | Redemption frequency | Redemption notice period |
|---------------------------------|--------------|--------------|------------------------|-------------------------|--------------------------------|
| Common collective trust fund | \$ 3,322,917 | \$ 3,990,859 | N/A | Daily | None |

6. Party-in-interest transactions

Some of the Plan's investments are shares of interest-bearing cash accounts managed by the Trustee as defined by the Plan and, therefore, these transactions qualify as party-in-interest transactions. During 2024, administrative expenses include \$95,746 paid to the Plan's third party administrator, \$25,000 to the Plan's audit firm, and \$38,189 to the Plan's investment advisor.

7. Plan termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA. In the event of Plan termination, participants will become 100% vested in all of their account balances.

8. Tax status

The Plan, a mass-submitter prototype plan, obtained its latest determination letter on June 30, 2020, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code (the Code). The Plan Administrator believes that the Plan is designed, and is currently being operated, in compliance with the applicable requirements of the Code.

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

9. Reconciliation of the financial statements to the Form 5500

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

| December 31, | 2024 | 2023 |
|--|--------------|--------------|
| Net assets available for benefits per the financial statements | \$ 7,952,427 | \$ 7,270,546 |
| Refunds of excess contributions | 86,534 | 111,825 |
| Net assets available for benefits per the Form 5500 | \$ 8,038,961 | \$ 7,382,371 |

The following is a reconciliation of benefits paid to participants per the financial statements to the Form 5500:

| Year ended December 31, 2024 | |
|--|--------------|
| Benefits paid to participants per the financial statements | \$ 1,022,358 |
| Prior year excess contributions refunded in 2024 | 111,825 |
| Benefits paid to participants per the Form 5500 | \$ 1,134,183 |

The following is a reconciliation of contributions per the financial statements to the Form 5500:

| Year ended December 31, 2024 | |
|--|--------------|
| Contributions per the financial statements | \$ 1,217,814 |
| Refunds of excess contributions | 86,534 |
| Contributions per the Form 5500 | \$ 1,304,348 |

ELEVATE CARE, INC. 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

9. Reconciliation of the financial statements to the Form 5500 (continued)

The following is a reconciliation of the increase in net assets available for benefits per the financial statements to the increase in net assets available for benefits per the Form 5500:

| <u>Year ended December 31, 2024</u> | |
|---|------------|
| Increase in net assets available for benefits | |
| per the financial statements | \$ 681,881 |
| Refunds of excess contributions | 86,534 |
| Prior year excess contributions paid in 2024 | (111,825) |
| | <hr/> |
| Increase in net assets available for benefits | |
| per the Form 5500 | \$ 656,590 |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(i) – Schedule of assets (held at end of year)

| (a) | (b) Identity of issuer, borrower, lessor or similar party | (c) Description of investment | (d) Cost | (e) Current value |
|--|--|---|----------|----------------------|
| Participant-directed 401(k) investments: | | | | |
| Mutual funds: | | | | |
| | American Funds | American Funds 2010 Target Date Retirement Fund | ** | \$ 363 |
| | American Funds | American Funds 2015 Target Date Retirement Fund | ** | 363 |
| | American Funds | American Funds 2020 Target Date Retirement Fund | ** | 10,395 |
| | American Funds | American Funds 2025 Target Date Retirement Fund | ** | 12,238 |
| | American Funds | American Funds 2030 Target Date Retirement Fund | ** | 53,390 |
| | American Funds | American Funds 2035 Target Date Retirement Fund | ** | 66,361 |
| | American Funds | American Funds 2040 Target Date Retirement Fund | ** | 15,162 |
| | American Funds | American Funds 2045 Target Date Retirement Fund | ** | 14,614 |
| | American Funds | American Funds 2050 Target Date Retirement Fund | ** | 15,812 |
| | American Funds | American Funds 2055 Target Date Retirement Fund | ** | 7,106 |
| | American Funds | American Funds 2060 Target Date Retirement Fund | ** | 191,172 |
| | American Funds | American Funds American Balanced Fund | ** | 625,564 |
| | American Funds | American Funds Capital World Growth and Income Fund | ** | 88,154 |
| | American Funds | American Funds New World Fund | ** | 46,999 |
| | American Funds | American Funds SMALLCAP World Fund | ** | 55,550 |
| | American Funds | American Funds The Bond Fund of America | ** | 32,728 |
| | Dodge & Cox | Dodge & Cox Income Fund | ** | 95,247 |
| | JP Morgan | JP Morgan Large Cap Growth Fund | ** | 500,980 |
| * | Mid Atlantic Trust | Deposit Management Program I | ** | 1,001,170 |
| | T. Rowe Price | T. Rowe Price Value Fund I | ** | 64,425 |
| | Vanguard | Vanguard 500 Index Fund | ** | 811,723 |
| | Vanguard | Vanguard Mid-Cap Index Fund | ** | 216,579 |
| | Vanguard | Vanguard International Value Fund | ** | 37,511 |
| | Vanguard | Vanguard Small Cap Value Index Fund | ** | 79,987 |
| | Vanguard | Vanguard Small-Cap Growth Index Fund | ** | 253,292 |
| | William Blair Funds | William Blair International Leaders Fund | ** | 99,004 |
| Total mutual funds | | | | 4,395,889 |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)

DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(i) – Schedule of assets (held at end of year)

| (a) | (b) Identity of issuer, borrower, lessor or similar party | (c) Description of investment | (d) Cost | (e) Current value |
|-----|--|--|----------|----------------------|
| | Participant-directed 401(k) investments: (continued) | | | |
| | Common collective trust fund: | | | |
| | Reliance Trust | Reliance Trust Stable Value Fund | ** | \$ 3,322,917 |
| * | Mid Atlantic Trust | Mid Atlantic Master Cash Account | ** | 18,561 |
| | | Total investments | | 7,737,367 |
| * | Notes receivable from participants | Interest rates range from 4.25% to 9.50% | | 333,313 |
| | Total assets held at end of year | | | \$ 8,070,680 |

*Represents a party-in-interest.

**Cost information is not required for participant-directed investments.

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS

YEAR ENDED DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(a) – Schedule of delinquent participant contributions

| Participant contributions transferred late to Plan | Total that constitutes nonexempt prohibited transactions | | | Total fully corrected under VFCP and PTE 2002-51 |
|---|---|---|---|--|
| | Contributions not corrected | Contributions corrected outside VFCP | Contributions pending correction in VFCP | |
| Check here if late participant loan repayments are included <input type="checkbox"/> | | | | |
| Period ended January 12, 2024 | \$ 327 | | \$ 327 | |
| Period ended January 26, 2024 | 327 | | 327 | |
| Period ended February 9, 2024 | 327 | | 327 | |
| Period ended February 12, 2024 | 28 | | 28 | |
| Period ended February 23, 2024 | 327 | | 327 | |
| Period ended February 26, 2024 | 71 | | 71 | |
| Period ended March 8, 2024 | 302 | | 302 | |
| Period ended March 11, 2024 | 31 | | 31 | |
| Period ended March 22, 2024 | 327 | | 327 | |
| Period ended March 25, 2024 | 743 | | 743 | |
| Period ended April 5, 2024 | 327 | | 327 | |
| Period ended April 8, 2024 | 79 | | 79 | |
| Period ended April 19, 2024 | 327 | | 327 | |
| Period ended April 22, 2024 | 110 | | 110 | |
| Period ended May 3, 2024 | 327 | | 327 | |
| Period ended May 6, 2024 | 29 | | 29 | |
| Period ended May 17, 2024 | 327 | | 327 | |
| Period ended May 20, 2024 | 64 | | 64 | |
| Period ended May 31, 2024 | 327 | | 327 | |
| Period ended June 3, 2024 | 28 | | 28 | |
| Period ended June 14, 2024 | 395 | | 395 | |
| Period ended June 17, 2024 | 30 | | 30 | |
| Period ended June 28, 2024 | 377 | | 377 | |
| Period ended July 1, 2024 | 29 | | 29 | |
| Period ended July 4, 2024 | 50 | | 50 | |
| Period ended July 12, 2024 | 327 | | 327 | |
| Period ended July 15, 2024 | 28 | | 28 | |
| Period ended July 24, 2024 | 303 | | 303 | |
| Period ended July 26, 2024 | 327 | | 327 | |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS (CONTINUED)

YEAR ENDED DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(a) – Schedule of delinquent participant contributions

| Participant contributions transferred late to Plan | Total that constitutes nonexempt prohibited transactions | | Total fully corrected under VFCP and PTE 2002-51 |
|---|---|---|--|
| Check here if late participant loan repayments are included <input type="checkbox"/> | Contributions not corrected | Contributions corrected outside VFCP | |
| Period ended August 7, 2024 | \$ 50 | \$ 50 | |
| Period ended August 9, 2024 | 327 | 327 | |
| Period ended August 12, 2024 | 29 | 29 | |
| Period ended August 21, 2024 | 100 | 100 | |
| Period ended August 23, 2024 | 327 | 327 | |
| Total | \$ 7,454 | \$ 7,454 | |

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Department of the Treasury Internal Revenue Service

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).

2024

Department of Labor Employee Benefits Security Administration

Complete all entries in accordance with the instructions to the Form 5500.

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE, etc.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report.
C If the plan is a collectively-bargained plan, check here.
D Check box if filing under: Form 5558, automatic extension, the DFVC program, special extension.
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: Elevate Care, Inc. 401(k) Plan
1b Three-digit plan number (PN): 002
1c Effective date of plan: 01/01/2000
2a Plan sponsor's name and address: Elevate Care, Inc., 8150 Central Park Avenue, Skokie, IL 60076
2b Employer Identification Number (EIN): 36-3223168
2c Plan Sponsor's telephone number: (184) 767-4545
2d Business code: 541600

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.

Table with 4 columns: SIGN HERE, Signature, Date, Name. Rows for plan administrator, employer/plan sponsor, and DFE.

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

Form 5500 (2024) v. 240311

| | | |
|--|--|-------|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| | | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 2,531 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). | | |
| a(1) Total number of active participants at the beginning of the plan year | 6a(1) | 2,381 |
| a(2) Total number of active participants at the end of the plan year | 6a(2) | 1,725 |
| b Retired or separated participants receiving benefits | 6b | 23 |
| c Other retired or separated participants entitled to future benefits | 6c | 149 |
| d Subtotal. Add lines 6a(2), 6b, and 6c. | 6d | 1,897 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | 6e | 1 |
| f Total. Add lines 6d and 6e. | 6f | 1,898 |
| 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) | 379 |
| 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) | 344 |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h | 60 |
| 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 Characteristics Codes in the instructions:
2E 2F 2H 2J 2K 2T 3D 3H

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

| | |
|---|---|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input type="checkbox"/> Insurance | (1) <input type="checkbox"/> Insurance |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input checked="" type="checkbox"/> Trust | (3) <input checked="" type="checkbox"/> Trust |
| (4) <input type="checkbox"/> General assets of the sponsor | (4) <input type="checkbox"/> 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)

| | |
|---|--|
| <p>a Pension Schedules</p> <p>(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p> <p>(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____</p> <p>(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)</p> | <p>b General Schedules</p> <p>(1) <input checked="" type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information – Small Plan)</p> <p>(3) <input type="checkbox"/> A (Insurance Information) – Number Attached _____</p> <p>(4) <input checked="" type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p> |
|---|--|

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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 _____

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS

YEAR ENDED DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(a) – Schedule of delinquent participant contributions

| Participant contributions transferred late to Plan | Total that constitutes nonexempt prohibited transactions | | | Total fully corrected under VFCP and PTE 2002-51 |
|---|---|---|---|--|
| Check here if late participant loan repayments are included <input type="checkbox"/> | Contributions not corrected | Contributions corrected outside VFCP | Contributions pending correction in VFCP | |
| Period ended January 12, 2024 | \$ 327 | | \$ 327 | |
| Period ended January 26, 2024 | 327 | | 327 | |
| Period ended February 9, 2024 | 327 | | 327 | |
| Period ended February 12, 2024 | 28 | | 28 | |
| Period ended February 23, 2024 | 327 | | 327 | |
| Period ended February 26, 2024 | 71 | | 71 | |
| Period ended March 8, 2024 | 302 | | 302 | |
| Period ended March 11, 2024 | 31 | | 31 | |
| Period ended March 22, 2024 | 327 | | 327 | |
| Period ended March 25, 2024 | 743 | | 743 | |
| Period ended April 5, 2024 | 327 | | 327 | |
| Period ended April 8, 2024 | 79 | | 79 | |
| Period ended April 19, 2024 | 327 | | 327 | |
| Period ended April 22, 2024 | 110 | | 110 | |
| Period ended May 3, 2024 | 327 | | 327 | |
| Period ended May 6, 2024 | 29 | | 29 | |
| Period ended May 17, 2024 | 327 | | 327 | |
| Period ended May 20, 2024 | 64 | | 64 | |
| Period ended May 31, 2024 | 327 | | 327 | |
| Period ended June 3, 2024 | 28 | | 28 | |
| Period ended June 14, 2024 | 395 | | 395 | |
| Period ended June 17, 2024 | 30 | | 30 | |
| Period ended June 28, 2024 | 377 | | 377 | |
| Period ended July 1, 2024 | 29 | | 29 | |
| Period ended July 4, 2024 | 50 | | 50 | |
| Period ended July 12, 2024 | 327 | | 327 | |
| Period ended July 15, 2024 | 28 | | 28 | |
| Period ended July 24, 2024 | 303 | | 303 | |
| Period ended July 26, 2024 | 327 | | 327 | |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS (CONTINUED)

YEAR ENDED DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(a) – Schedule of delinquent participant contributions

| Participant contributions transferred late to Plan | Total that constitutes nonexempt prohibited transactions | | | Total fully corrected under VFCP and PTE 2002-51 |
|---|---|---|---|--|
| Check here if late participant loan repayments are included <input type="checkbox"/> | Contributions not corrected | Contributions corrected outside VFCP | Contributions pending correction in VFCP | |
| Period ended August 7, 2024 | \$ 50 | | \$ 50 | |
| Period ended August 9, 2024 | 327 | | 327 | |
| Period ended August 12, 2024 | 29 | | 29 | |
| Period ended August 21, 2024 | 100 | | 100 | |
| Period ended August 23, 2024 | 327 | | 327 | |
| Total | \$ 7,454 | | \$ 7,454 | |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(i) – Schedule of assets (held at end of year)

| (a) | (b) Identity of issuer, borrower, lessor or similar party | (c) Description of investment | (d) Cost | (e) Current value |
|--|--|---|----------|----------------------|
| Participant-directed 401(k) investments: | | | | |
| Mutual funds: | | | | |
| | American Funds | American Funds 2010 Target Date Retirement Fund | ** | \$ 363 |
| | American Funds | American Funds 2015 Target Date Retirement Fund | ** | 363 |
| | American Funds | American Funds 2020 Target Date Retirement Fund | ** | 10,395 |
| | American Funds | American Funds 2025 Target Date Retirement Fund | ** | 12,238 |
| | American Funds | American Funds 2030 Target Date Retirement Fund | ** | 53,390 |
| | American Funds | American Funds 2035 Target Date Retirement Fund | ** | 66,361 |
| | American Funds | American Funds 2040 Target Date Retirement Fund | ** | 15,162 |
| | American Funds | American Funds 2045 Target Date Retirement Fund | ** | 14,614 |
| | American Funds | American Funds 2050 Target Date Retirement Fund | ** | 15,812 |
| | American Funds | American Funds 2055 Target Date Retirement Fund | ** | 7,106 |
| | American Funds | American Funds 2060 Target Date Retirement Fund | ** | 191,172 |
| | American Funds | American Funds American Balanced Fund | ** | 625,564 |
| | American Funds | American Funds Capital World Growth and Income Fund | ** | 88,154 |
| | American Funds | American Funds New World Fund | ** | 46,999 |
| | American Funds | American Funds SMALLCAP World Fund | ** | 55,550 |
| | American Funds | American Funds The Bond Fund of America | ** | 32,728 |
| | Dodge & Cox | Dodge & Cox Income Fund | ** | 95,247 |
| | JP Morgan | JP Morgan Large Cap Growth Fund | ** | 500,980 |
| * | Mid Atlantic Trust | Deposit Management Program I | ** | 1,001,170 |
| | T. Rowe Price | T. Rowe Price Value Fund I | ** | 64,425 |
| | Vanguard | Vanguard 500 Index Fund | ** | 811,723 |
| | Vanguard | Vanguard Mid-Cap Index Fund | ** | 216,579 |
| | Vanguard | Vanguard International Value Fund | ** | 37,511 |
| | Vanguard | Vanguard Small Cap Value Index Fund | ** | 79,987 |
| | Vanguard | Vanguard Small-Cap Growth Index Fund | ** | 253,292 |
| | William Blair Funds | William Blair International Leaders Fund | ** | 99,004 |
| Total mutual funds | | | | 4,395,889 |

ELEVATE CARE, INC. 401(k) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)

DECEMBER 31, 2024

Employer Identification Number 36-3223168

Plan Number 002

Schedule H, Part IV, Line 4(i) – Schedule of assets (held at end of year)

| (a) | (b) Identity of issuer, borrower, lessor or similar party | (c) Description of investment | (d) Cost | (e) Current value |
|-----|--|--|----------|----------------------|
| | Participant-directed 401(k) investments: (continued) | | | |
| | Common collective trust fund: | | | |
| | Reliance Trust | Reliance Trust Stable Value Fund | ** | \$ 3,322,917 |
| * | Mid Atlantic Trust | Mid Atlantic Master Cash Account | ** | 18,561 |
| | | Total investments | | 7,737,367 |
| * | Notes receivable from participants | Interest rates range from 4.25% to 9.50% | | 333,313 |
| | Total assets held at end of year | | | \$ 8,070,680 |

*Represents a party-in-interest.

**Cost information is not required for participant-directed investments.