

<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: 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;">2023</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 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

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>MEDICALODGES, INC. EMPLOYEE STOCK OWNERSHIP 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>MEDICALODGES, INC.</u></p> <p><u>PO BOX 509</u> <u>COFFEYVILLE, KS 67337</u></p>	<p>1c Effective date of plan <u>11/01/1990</u></p> <p>2b Employer Identification Number (EIN) <u>48-0698712</u></p> <p>2c Plan Sponsor's telephone number <u>620-251-6700</u></p> <p>2d Business code (see instructions) <u>623000</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.	11/11/2025	SCOTT HINES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	11/11/2025	SCOTT HINES
	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: a Sponsor's name c Plan Name	4b EIN
	4d PN

5 Total number of participants at the beginning of the plan year	5	1724
---	----------	------

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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		
	6a(1)	875
	6a(2)	772
	6b	27
	6c	757
	6d	1556
	6e	11
	6f	1567
	6g(1)	1828
	6g(2)	1530
	6h	91

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:
2P 3I

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

(1) **R** (Retirement Plan Information)

(2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(4) **DCG** (Individual Plan Information) – Number Attached 0

(5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

(1) **H** (Financial Information)

(2) **I** (Financial Information – Small Plan)

(3) **A** (Insurance Information) – Number Attached _____

(4) **C** (Service Provider Information)

(5) **D** (DFE/Participating Plan Information)

(6) **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 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> 2023 This Form is Open to Public Inspection.
--	--	---

For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

A Name of plan MEDICALODGES, INC. EMPLOYEE STOCK OWNERSHIP PLAN	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 MEDICALODGES, INC.	D Employer Identification Number (EIN) 48-0698712	

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)

(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"/>

(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.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024	
A Name of plan MEDICALODGES, INC. EMPLOYEE STOCK OWNERSHIP PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 MEDICALODGES, INC.	D Employer Identification Number (EIN) 48-0698712

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)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	182873	185604
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	9223952	10004519
(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	9406825	10190123
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	1834547	1541311
k Total liabilities (add all amounts in lines 1g through 1j)	1k	1834547	1541311
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	7572278	8648812

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)	325640	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)	434420	
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		760060
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends:			
(A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	1014951	
(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)		
c Other income	2c		2731
d Total income. Add all income amounts in column (b) and enter total	2d		1777742

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	654268	
(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)		654268
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		34091
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)		
(2) Contract administrator fees.....	2i(2)		
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		0
j Total expenses. Add all expense amounts in column (b) and enter total	2j		688359

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		1089383
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		12849

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: MEARA WELCH BROWNE, P.C.

(2) EIN: 43-1618427

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.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		5000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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)
MEDICALODGES INC 401(K) PROFIT SHARING PLAN	48-0698712	001

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.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection.
--	---	---

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan <u>MEDICALODGES, INC. EMPLOYEE STOCK OWNERSHIP 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>MEDICALODGES, INC.</u>	D Employer Identification Number (EIN) <u>48-0698712</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	668804
---	---	--------

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): 42-0127290

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 ___/___/___ (MM/DD/YYYY) and the Opinion Letter serial number _____.

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
FINANCIAL STATEMENTS
OCTOBER 31, 2024 AND 2023

PREPARED BY



MEARA WELCH BROWNE, P.C.
CERTIFIED PUBLIC ACCOUNTANTS & CONSULTANTS

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
OCTOBER 31, 2024 AND 2023

TABLE OF CONTENTS

	<u>Page</u>
Independent Auditor's Report	1-2
Financial Statements	
Statements of Net Assets Available for Benefits as of October 31, 2024 and 2023	3
Statements of Changes in Net Assets Available for Benefits for the Years Ended October 31, 2024 and 2023	4
Notes to Financial Statements	5-10
Supplemental Information	
Schedule H, Line 4i – Schedule of Assets (Held at End of Year)	11



Meara Welch Browne, P.C.

4121 West 83rd Street, Suite 260

Prairie Village, KS 66208-5472

www.mwbpc.com

(816) 561-1400

Independent Auditor's Report

To the Participants, Administrator, and Trustees of
of Medicalodges, Inc. Employee Stock Ownership Plan

Opinion

We have audited the accompanying financial statements of Medicalodges, Inc. Employee Stock Ownership Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits as of October 31, 2024 and 2023, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits of Medicalodges, Inc. Employee Stock Ownership Plan as of October 31, 2024 and 2023, and the changes in its net assets available for benefits for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

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 Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Medicalodges, Inc. Employee Stock Ownership 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 audit opinion.

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Medicalodges, Inc. Employee Stock Ownership 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 Medicalodges, Inc. Employee Stock Ownership Plan's ability to continue as a going concern for a reasonable period of time.

Supplemental Schedules Required by ERISA

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

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

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

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.

Meara Welch Browne

Prairie Village, KS
November 7, 2025

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
OCTOBER 31, 2024 AND 2023

	2024			2023		
	Allocated	Unallocated	Total	Allocated	Unallocated	Total
Cash and cash equivalents	\$ -	\$ 185,604	\$ 185,604	\$ -	\$ 182,873	\$ 182,873
Interest receivable	-	-	-	-	-	-
Investments, at fair value:						
Medicalodges, Inc. common stock	<u>8,666,831</u>	<u>1,337,688</u>	<u>10,004,519</u>	<u>7,779,914</u>	<u>1,444,038</u>	<u>9,223,952</u>
Total investments	<u>8,666,831</u>	<u>1,337,688</u>	<u>10,004,519</u>	<u>7,779,914</u>	<u>1,444,038</u>	<u>9,223,952</u>
Total assets	<u>8,666,831</u>	<u>1,523,292</u>	<u>10,190,123</u>	<u>7,779,914</u>	<u>1,626,911</u>	<u>9,406,825</u>
Distribution payable			-	1,687	-	1,687
Note payable	-	1,541,311	1,541,311	-	1,832,860	1,832,860
Total liabilities	<u>-</u>	<u>1,541,311</u>	<u>1,541,311</u>	<u>1,687</u>	<u>1,832,860</u>	<u>1,834,547</u>
Net assets available for benefits	<u>\$ 8,666,831</u>	<u>\$ (18,019)</u>	<u>\$ 8,648,812</u>	<u>\$ 7,778,227</u>	<u>\$ (205,949)</u>	<u>\$ 7,572,278</u>

The accompanying notes are an integral part of the financial statements.

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
OCTOBER 31, 2024 AND 2023

	2024			2023		
	Allocated	Unallocated	Total	Allocated	Unallocated	Total
Investment income:						
Net unrealized appreciation (depreciation) in estimated fair value of investments	\$ 851,060	\$ 162,846	\$ 1,013,906	\$ (1,084,611)	\$ (242,580)	\$ (1,327,191)
Interest income		3,775	3,775	-	1,272	1,272
Contributions:						
Employer contributions of 15,570 (2024) and 15,659 (2023) shares of common stock of Medicalodges, Inc.	434,420	325,640	760,060	500,296	325,640	825,936
Other Transactions:						
ROS (Interest)	28,005	(28,005)	-	29,094	(29,094)	-
ROS (Principal)	239,503	(239,503)	-	211,276	(211,276)	-
Stock contribution adjustment	2,731	(2,731)	-	30,993	-	30,993
Total additions to net assets	<u>1,555,719</u>	<u>222,022</u>	<u>1,777,741</u>	<u>(312,952)</u>	<u>(156,038)</u>	<u>(468,990)</u>
Deductions from net assets:						
Distributions to participants	654,266		654,266	937,389	-	937,389
Transfers to Medicalodges, Inc. 401(k) Plan	12,849		12,849	14,351	-	14,351
Operating expenses:						
Interest expense on note payable		34,091	34,091	-	39,415	39,415
Total deductions from net assets	<u>667,115</u>	<u>34,091</u>	<u>701,206</u>	<u>951,740</u>	<u>39,415</u>	<u>991,155</u>
Net increase (decrease)	888,604	187,931	1,076,535	(1,264,692)	(195,453)	(1,460,145)
Net assets available for benefits, beginning of year	<u>7,778,227</u>	<u>(205,950)</u>	<u>7,572,277</u>	<u>9,042,919</u>	<u>(10,497)</u>	<u>9,032,422</u>
Net assets available for benefits, end of year	<u>\$ 8,666,831</u>	<u>\$ (18,019)</u>	<u>\$ 8,648,812</u>	<u>\$ 7,778,227</u>	<u>\$ (205,950)</u>	<u>\$ 7,572,277</u>

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

NOTE 1: DESCRIPTION OF THE PLAN

General

The following description of the Medicalodges, Inc. (the Company) Employee Stock Ownership Plan (the Plan) provides only general information. Employees should refer to the pamphlet “Medicalodges, Inc. Summary Plan Description for Employees Stock Ownership Plan” for a more complete description of the Plan’s provisions.

The Company established the Plan effective as of November 1, 1990. As of November 1, 1998, the Plan operates as a leveraged employee stock ownership plan (ESOP), which is designed to comply with Section 4975(e)(7) and the regulations thereunder of the Internal Revenue Code (IRC) of 1986, as amended and is subject to the applicable provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). A committee appointed by the Board of Directors of the Company administers the Plan. Trustees are responsible for holding, managing and controlling all contributions made under the Plan. The Trustees’ actions are governed by a trust agreement (Trust), which forms part of the Plan.

On October 30, 2019, the Plan entered into a \$2,946,629 promissory note with the Company (see note 5) in order to purchase 86,159 shares of the Company’s common stock. As the Plan makes each payment of principal, an appropriate percentage of stock will be allocated to eligible employees' accounts in accordance with applicable regulations under the IRC.

Eligibility

Employees of the Company are generally eligible to participate in the Plan after one year of service, providing they worked at least 1,000 hours of service during the plan year and are at least 21 years old. Participants who do not have at least 1,000 hours of service during such plan year, or are not employed on the last working day of the plan year, are generally not eligible for an allocation of Company contributions for such year. Vesting in employee accounts is based on years of continuous service based on the following schedule or upon attainment of age 65 (with five years of service) or upon death or disability.

<u>Vesting Service (whole years)</u>	<u>Vesting Percentage</u>
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

Payment of Benefits

Distributions from the Plan will be made when a participant retires, becomes deceased (in which case, payment shall be made to his or her beneficiary or, if none, his or her legal representatives) or becomes disabled. Distributions are made in cash. Participants who terminate employment, other than those stated above, will not receive distributions until after the Plan’s debt is paid in full for loan stock. They will begin receiving distributions for non-loan stock five years after termination.

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

Voting Rights

In certain situations, each participant is entitled to exercise voting rights attributable to the shares allocated to his or her account, and is notified by the Trustees prior to the time that such rights are to be exercised. Trustees are permitted to vote any share for which a participant has not given instructions.

Put Option

Under federal income tax regulations, the employer stock that is held by the Plan and its participants and is not readily tradable on an established market, or is subject to trading limitations, includes a put option. The put option is a right to demand that the Company buy any shares of its stock distributed to participants for which there is no market. The put price is representative of the current appraised value of the stock. The Company can pay for the purchase with interest over a period of five years. The purpose of the put option is to ensure that the participant has the ability to ultimately obtain cash.

Plan Termination

The Company reserves the right to terminate the Plan at any time, subject to Plan provisions and ERISA. Upon such termination of the Plan, the interest of each participant in the trust fund will be distributed to such participant or his or her beneficiary at the time prescribed by the Plan terms and the IRC. Upon termination of the Plan, the committee shall direct the Trustee to pay all liabilities and expenses of the trust fund and to sell shares of financed stock held in the loan suspense account to the extent it determines such sale to be necessary in order to repay the loan.

Forfeitures

After five breaks in service due to participants not working at least 501 hours in the plan year or not being employed, participants forfeit their non-vested shares. The Plan allocates forfeitures based on the ratio of each participant's total annual cash compensation to total cash compensation of all Plan participants. Forfeitures during the plan years ended October 31, 2024 and 2023 were \$79,263 and \$6,875, respectively.

Administrative Expenses

Certain expenses incurred in the administration of the Plan are paid directly by the Company.

Transfers to the Medicalodges, Inc. 401(k) Plan

If an active participant or a former participant attains age fifty-five and has completed at least ten years of participation in the Plan, the participant has the option to transfer a portion of the value of their stock to the Company's 401(k) Plan, as prescribed by the Internal Revenue Service (IRS).

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

Income Tax Status

The Plan has received a determination letter from the IRS dated October 22, 2013 that stated that the Plan, as then designed, was in compliance with the applicable requirements of the IRC and, therefore, the related trust is exempt from taxation. Once qualified, the Plan is required to operate in conformity with the IRC to maintain its qualification. The Plan administrator believes that the Plan is currently designed, and being operated, in compliance with the applicable requirements of the IRC. Therefore, they believe that the Plan was qualified, and the related trust was tax-exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of October 31, 2024 and 2023, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions within the United States of America; however, there are currently no audits for any tax periods in progress. The plan administrator believes it is no longer subject to income tax examinations for years prior to 2021.

NOTE 2: SUMMARY OF ACCOUNTING POLICIES

Basis of Accounting

The Plan's financial statements and schedules are prepared under the accrual method in conformity with accounting principles generally accepted in the United States of America.

Valuation of Investments

The Plan's investment in employer securities is stated at fair value as determined by an independent appraisal (see Note 3).

Payment of Benefits

Benefits are recorded when paid.

Use of Estimates

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

Risks and Uncertainties

The Plan invests in Company stock. The value of this stock is exposed to overall volatility risk related to Company performance. Due to the level of risk associated with this, it is reasonably possible that changes in the values of Company stock will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

NOTE 3: INVESTMENTS

The Plan's investments as of October 31, 2024 are nonparticipant-directed and consist of common shares of Medicalodges, Inc., which are presented in the following table:

	<u>Allocated</u>	<u>Unallocated</u>
Medicalodges, Inc. common shares:		
Number of shares	279,125	43,142
Cost	\$ 10,505,789	\$ 1,337,688
Fair value	\$ 8,666,831	\$ 1,337,688

The Plan's investments as of October 31, 2023 are nonparticipant-directed and consist of common shares of Medicalodges, Inc., which are presented in the following table:

	<u>Allocated</u>	<u>Unallocated</u>
Medicalodges, Inc. common shares:		
Number of shares	278,850	51,757
Cost	\$ 13,041,984	\$ 1,444,038
Fair value	\$ 7,779,914	\$ 1,444,038

The fair value of the Company stock at October 31, 2024 and 2023 was \$31.05 and \$27.90 per share. The Company's independent appraiser applies both the market approach and income approach in arriving at the fair value. The income approach includes assumptions of future increases in capacity as well as reimbursement rates and operating cost containment.

NOTE 4: FAIR VALUE MEASUREMENTS

ASC 820-10 classifies investments into Level 1, which refers to securities traded in an active market; Level 2, which refers to securities not traded on an active market but for which observable market inputs are readily available or Level 1 securities where there is a contractual restriction; and Level 3, which refers to securities not traded in an active market and for which no significant observable market inputs are available. As required by ASC 820-10, at October 31, 2024 and 2023, all of the Plan's investments were classified as Level 3, with a fair value of \$10,004,519 and \$9,223,952, respectively.

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

The following table reconciles the beginning and ending balances of the fair value measurements using significant unobservable inputs (Level 3) for the years ended October 31, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Beginning balance	\$ 9,223,952	\$ 10,983,470
Total unrealized gains included in changes in net assets available for benefits	1,013,906	(1,327,191)
Employer contributions of common stock	434,420	500,296
Interest Contribution	34,091	39,415
Total transfers to Medicalodges 401(k) Plan	(12,849)	(14,351)
Stock contribution adjustment	(644)	19,117
Distributions paid	(654,266)	(937,389)
Interest expense	<u>(34,091)</u>	<u>(39,415)</u>
Ending balance	<u>\$ 10,004,519</u>	<u>\$ 9,223,952</u>

The investments classified by level for the years ended October 31, 2024 and 2023 are summarized as follows:

	<u>2024</u>		<u>2023</u>	
	<u>Level 3</u>	<u>Total</u>	<u>Level 3</u>	<u>Total</u>
Medicalodges, Inc. common shares	<u>\$ 10,004,519</u>	<u>\$ 10,004,519</u>	<u>\$ 9,223,952</u>	<u>\$ 9,223,952</u>
	<u>\$ 10,004,519</u>	<u>\$ 10,004,519</u>	<u>\$ 9,223,952</u>	<u>\$ 9,223,952</u>

NOTE 5: NOTE PAYABLE

On October 30, 2019, the Company entered into a new note with the Plan for \$2,946,629 which bears interest at a rate of 1.86% per annum and matures October 31, 2029. The shares purchased were pledged as collateral for the note. At October 31, 2024 and 2023, the outstanding balance on the note was \$1,541,311 and \$1,832,860, respectively.

The scheduled amortization of the loan for the next five years and thereafter is as following:

<u>Year ending</u> <u>October 31,</u>	<u>Amount</u>
2025	296,971
2026	302,495
2027	308,121
2028	313,852
2029	<u>319,872</u>
Total	<u>\$ 1,541,311</u>

MEDICALODGES, INC.
EMPLOYEE STOCK OWNERSHIP PLAN
NOTES TO FINANCIAL STATEMENTS

NOTE 6: ADMINISTRATION OF PLAN ASSETS

Company contributions are held and managed by the Third Party Administrator, who invests cash received and interest income, and makes distributions to participants.

The Company's ESOP administrative committee, officers, or employees of the Company perform certain administrative functions. No such officer or employee receives compensation from the Plan.

The Company pays approximately \$85,000 annually to third parties for administrative costs.

NOTE 7: RELATED PARTY AND PARTY IN INTEREST TRANSACTIONS

The Plan invests in Company common stock and has indebtedness guaranteed by the Company. These are related party and party in interest transactions. As described in Note 1, the Company pays all plan administrative expenses. The Plan has a number of service providers. Such providers are parties in interest under ERISA, as listed below.

The Company is the Plan Sponsor. The Company made contributions of Medicalodges, Inc. common stock during the years ended October 31, 2024 and 2023. The Company made stock contributions of 15,571 and 15,659 shares of common stock with a fair value of \$434,420 and \$500,296 respectively, and cash contributions of \$325,640 for the years ended October 31, 2024 and 2023. Total contributions were \$760,060 and \$825,936 for October 31, 2024 and 2023, respectively.

Principal Life Insurance Company is the Third Party Administrator. Administrative fees are paid by the Plan Sponsor.

Stern Brothers Valuation Advisors are the Appraisers of the Plan. Administrative fees are paid by the Plan Sponsor.

Meara Welch Browne, P.C. is the Auditor of the Plan. Audit fees are paid by the Plan Sponsor.

NOTE 8: SUBSEQUENT EVENTS

The Company has evaluated subsequent events from the date of the financial statements through November 7, 2025, the date which the financial statements were available to be issued.

Supplemental Information

MEDICALODGES, INC.
 EMPLOYEE STOCK OWNERSHIP PLAN
 EIN: 48-0698712
 PLAN NUMBER: 002
 SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
 OCTOBER 31, 2024

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current Value
-----	---	---	----------	-------------------

*	Medicalodges, Inc.	320,261 shares of common stock	\$ 11,843,477	\$ 10,004,519
---	--------------------	--------------------------------	---------------	---------------

* Party-in-interest to the Plan