

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2025 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☒ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan HOLLANDER HOSPITALITY LLC FLEXIBLE BENEFIT PLAN
1b	Three-digit plan number (PN) ▶ 509
1c	Effective date of plan 01/01/2025
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) HOLLANDER HOSPITALITY LLC 119 N COMMERCIAL ST STE 165 BELLINGHAM, WA 98225-4452
2b	Employer Identification Number (EIN) 91-1746890
2c	Plan Sponsor's telephone number 360-647-1916
2d	Business code (see instructions) 721110

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.	08/30/2026	MEGHAN DOWN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor CEHAS PLAN ADMINISTRATORS, LLC PO BOX 70070 RICHMOND, VA 23255-0070	3b Administrator's EIN 99-3481394																						
	3c Administrator's telephone number 866-906-1747																						
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	5 232																						
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.....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2" style="height: 20px;"></td></tr> <tr><td style="width: 15%;">6a(1)</td><td style="text-align: right;">232</td></tr> <tr><td>6a(2)</td><td style="text-align: right;">232</td></tr> <tr><td>6b</td><td style="text-align: right;">0</td></tr> <tr><td>6c</td><td style="text-align: right;">0</td></tr> <tr><td>6d</td><td style="text-align: right;">232</td></tr> <tr><td>6e</td><td></td></tr> <tr><td>6f</td><td style="text-align: right;">232</td></tr> <tr><td>6g(1)</td><td></td></tr> <tr><td>6g(2)</td><td></td></tr> <tr><td>6h</td><td></td></tr> </table>			6a(1)	232	6a(2)	232	6b	0	6c	0	6d	232	6e		6f	232	6g(1)		6g(2)		6h	
6a(1)	232																						
6a(2)	232																						
6b	0																						
6c	0																						
6d	232																						
6e																							
6f	232																						
6g(1)																							
6g(2)																							
6h																							
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7																						

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

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

4A

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1)** ☐ **R** (Retirement Plan Information)
- (2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4)** ☐ **DCG** (Individual Plan Information) – Number Attached _____
- (5)** ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1)** ☐ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **A** (Insurance Information) – Number Attached 1
- (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 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan HOLLANDER HOSPITALITY LLC FLEXIBLE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 HOLLANDER HOSPITALITY LLC	D Employer Identification Number (EIN) 91-1746890

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier HOLLANDER HOSPITALITY LLC					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-1746890	72111	116	232	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 81129	(b) Total amount of fees paid 624197
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid CEHAS PLAN ADMINISTRATORS, LLC PO BOX 70070 RICHMOND, VA 23255
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	46122	BROKER AGENT	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid PCF HOLDCO DBA RICE INSURANCE 2745 WEST 600 N SUITE 400 LINDON, UT 84042

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	35007	BROKER AGENT	3

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

ASCEND TPA, LLC

35 ASHBOURNE DR
WESTLAKE, OH 44145

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	2166	THIRD PARTY ADMINSTRATOR	5

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

RX VALET

1580 ATKINSON RD
LAWRENCEVILLE, GA 30043

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	1376	PRESCRIPTION DISCOUNT CARD	0

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

RECURO HEALTH

2100 NORTH GREENVILLE
RICHARDSON, TX 75082

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	11478	TELE-HEALTH & CONCIERGE CARE PROVIDER	0

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

ONETECHNOLOGY, LLC

312 MAXWELL RD.
SUITE 100
ALPHARETTA, GA 30009

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	29343	TECHNOLOGY SERVICES	0

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

PROCEDANT

22693 EAST LORDS WAY
QUEEN CREEK, AZ 85142

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	11477	COMPLIANCE PROTECTION COVERAGE	0

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

HEALTH PERX

PO BOX 803475
DALLAS, TX 75380

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	3107	DISCOUNT RX CARD SERVICES	0

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

ELLIS MANAGEMENT GROUP , LLC

12340 PURBROOK WALK
HENRICO, VA 23233

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	2494	BROKER AGENT	3

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

CEHAS PLAN ADMINISTRATORS, LLC

PO BOX 70070
RICHMOND, VA 23255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	540697	THIRD PARTY ADMINISTRATOR	5

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

AMAZE PBC DBA AMAZE HEALTH

PO BOX 329
LONGMONT, CO 80502

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	22054	TELE-HEALTH & CONCIERGE CARE PROVIDER	0

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

Row Labels	Sum of CommissionAmount	
Ben Eaton	\$	35,007.42
CG Corp	\$	46,122.56
(blank)		
Grand Total	\$	81,129.98

Row Labels	Sum of VendorFeeAmount
Amaze	\$ 22,054.93
Tele-health and Concierge Care Provider	\$ 22,054.93
CEHAS Admin - Claims Admin Fee	\$ 27,391.87
Claims Admin Fee	\$ 27,391.87
CEHAS Admin - Sales Administration	\$ 1,003.26
Sales Fee	\$ 1,003.26
CEHAS Front End Admin Fee EH	\$ 25,052.06
Revenue Share	\$ 25,052.06
CEHAS Front End Admin Fee Post 030125 w CPC	\$ 50,271.57
Revenue Share	\$ 50,271.57
CEHAS Front End Admin Fee Pre 08.01.24 INDEMNIFICATION	\$ 3,611.10
Revenue Share	\$ 3,611.10
CEHAS Plan Administrators - Carrier Fee	\$ 24,144.82
Carrier Fee	\$ 24,144.82
CEHAS Plan Administrators - Claims Fund	\$ 181,545.51
Carrier Fee	\$ 22,349.28
Claims Admin Fee	\$ 25,662.66
Claims Fund	\$ 84,422.06
Underwriting Fee	\$ 49,111.51
CEHAS Plan Administrators - Underwriting Profit	\$ 53,451.38
Underwriting Fee	\$ 53,451.38
CG - Encompassing Health	\$ 97,965.42
General Admin Fee	\$ 97,965.42
CG CEHAS Post 03.01.25 INDEMNIFICATION	\$ 35,690.75
General Admin Fee	\$ 35,690.75
CG CEHAS Pre 08.01.24 INDEMNIFICATION	\$ 12,230.82
General Admin Fee	\$ 12,230.82
EMG LLC	\$ 2,494.97
Sales Fee	\$ 2,494.97
Health PERX	\$ 3,107.73
General Admin Fee	\$ 3,107.73
JCACP	\$ 3,652.92
Technology and Customer Service Fee	\$ 3,652.92
JCACP EH Pre 08.01.2024	\$ 12,495.30
Technology and Customer Service Fee	\$ 12,495.30
JCACP Post 03.01.25 INDEMNIFICATION	\$ 12,190.80
Technology and Customer Service Fee	\$ 12,190.80
Legacy Insurecap	\$ 11,477.21
Indemnification Cost	\$ 11,477.21
ONETechnology	\$ 29,343.40
Technology Fee	\$ 29,343.40
Recuro	\$ 11,478.90
Tele-health and Concierge Care Provider	\$ 11,478.90
RX Valet	\$ 1,376.23
General Admin Fee	\$ 1,376.23
Todd Houston	\$ 2,166.43
Captive Sales/CRM1 Management Assistant	\$ 2,166.43
(blank)	
(blank)	
Grand Total	\$ 624,197.38

CEHAS

\$ 540,697.58