# Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

**2025**

**This Form is Open to Public Inspection**

## Part I Annual Report Identification Information

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

**A** This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) _____

**B** This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

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

**D** Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**1b** Three-digit plan number (PN) ▶ 001

**1c** Effective date of plan 01/01/1991

**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)
NORTH COUNTRY HEALTH SYSTEM, INC.

189 PROUTY DRIVE
NEWPORT, VT 05855

**2b** Employer Identification Number (EIN)
03-0185556

**2c** Plan Sponsor's telephone number
802-334-3210

**2d** Business code (see instructions)
622000

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

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

| | | | |
|---|---|---|---|
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 10/09/2026 | ANITA FLAGG |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | | | |
| | **Signature of employer/plan sponsor** | Date | Enter name of individual signing as employer or plan sponsor |
| **SIGN HERE** | | | |
| | **Signature of DFE** | Date | Enter name of individual signing as DFE |

| | | | |
|---|---|---|---|
| **3a** | Plan administrator's name and address [X] Same as Plan Sponsor | **3b** | Administrator's EIN |
| | | **3c** | Administrator's telephone number |
| **4** | If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: | **4b** | EIN |
| **a** | Sponsor's name | **4d** | PN |
| **c** | Plan Name | | |

| | | | |
|---|---|---|---|
| **5** | Total number of participants at the beginning of the plan year | **5** | 934 |
| **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)** | 626 |
| **a(2)** | Total number of active participants at the end of the plan year | **6a(2)** | 639 |
| **b** | Retired or separated participants receiving benefits | **6b** | 15 |
| **c** | Other retired or separated participants entitled to future benefits | **6c** | 270 |
| **d** | Subtotal. Add lines **6a(2)**, **6b**, and **6c**. | **6d** | 924 |
| **e** | Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | **6e** | 8 |
| **f** | Total. Add lines **6d** and **6e**. | **6f** | 932 |
| **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)** | 934 |
| **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)** | 932 |
| **h** | Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. | **6h** | 0 |
| **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:

2F 2G 2L 2M 2R 2S 2T 3D 3H

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

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

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

**a Pension Schedules**

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

**b General Schedules**

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

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

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

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

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

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

Receipt Confirmation Code_____

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Insurance Information

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

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

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

OMB No. 1210-0110

**2025**

**This Form is Open to Public Inspection**

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

**A** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**B** Three-digit plan number (PN) ▶ 001

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORTH COUNTRY HEALTH SYSTEM, INC.

**D** Employer Identification Number (EIN)
03-0185556

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

**1** Coverage Information:

**(a)** Name of insurance carrier
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | (f) From | (g) To |
| 36-6071399 | 70688 | TT069347 | 932 | 01/01/2025 | 12/31/2025 |

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

| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|---|---|
| | |

**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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Part II Investment and Annuity Contract Information

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

| | | | |
|---|---|---|---|
| 4 | Current value of plan's interest under this contract in the general account at year end | 4 | 58477 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end | 5 | |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| b | Balance at the end of the previous year | | | 7b | 188857 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) | | | |
| | (2) Dividends and credits | 7c(2) | | | |
| | (3) Interest credited during the year | 7c(3) | 1922 | | |
| | (4) Transferred from separate account | 7c(4) | | | |
| | (5) Other (specify below) | 7c(5) | 114077 | | |
| | ▶ ADDITIONS TO FORFEITURES AND EBA | | | | |
| | (6)Total additions | | | 7c(6) | 115999 |
| d | Total of balance and additions (add lines **7b** and **7c(6)**). | | | 7d | 304856 |
| 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) | 246379 | | |
| | ▶ OTHER EXPENSES FROM UNALLOCATED ASSETS AND TRANSFER ADJUSTMENTS | | | | |
| | (5) Total deductions | | | 7e(5) | 246379 |
| f | Balance at the end of the current year (subtract line **7e(5)** from line **7d**) | | | 7f | 58477 |

## 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. ▶

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Insurance Information

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

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

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

OMB No. 1210-0110

**2025**

**This Form is Open to Public Inspection**

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

**A** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**B** Three-digit plan number (PN) ▶ 001

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORTH COUNTRY HEALTH SYSTEM, INC.

**D** Employer Identification Number (EIN)
03-0185556

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

**1** Coverage Information:

**(a)** Name of insurance carrier
TRANSAMERICA LIFE INSURANCE COMPANY

| **(b)** EIN | **(c)** NAIC code | **(d)** Contract or identification number | **(e)** Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | **(f)** From | **(g)** To |
| 39-0989781 | 86231 | TT069347 | 932 | 01/01/2025 | 12/31/2025 |

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

| **(a)** Total amount of commissions paid | **(b)** Total amount of fees paid |
|---|---|
| | |

**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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Part II Investment and Annuity Contract Information

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

| | | | |
|---|---|---|---|
| 4 | Current value of plan's interest under this contract in the general account at year end | 4 | 4539357 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end | 5 | |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| b | Balance at the end of the previous year | | | 7b | 4817587 |
| c | Additions: (1) Contributions deposited during the year | 7c(1) | 263683 | | |
| | (2) Dividends and credits | 7c(2) | | | |
| | (3) Interest credited during the year | 7c(3) | 135212 | | |
| | (4) Transferred from separate account | 7c(4) | | | |
| | (5) Other (specify below) | 7c(5) | 491794 | | |
| | ▶ FIXED FUND TRANSFERS IN AND LOAN PAYMENTS | | | | |
| | (6)Total additions | | | 7c(6) | 890689 |
| d | Total of balance and additions (add lines **7b** and **7c(6)**). | | | 7d | 5708276 |
| e | Deductions: | | | | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | 1053578 | | |
| | (2) Administration charge made by carrier | 7e(2) | 12852 | | |
| | (3) Transferred to separate account | 7e(3) | | | |
| | (4) Other (specify below) | 7e(4) | 102489 | | |
| | ▶ FIXED FUND TRANSFERS OUT AND LOANS ISSUED | | | | |
| | (5) Total deductions | | | 7e(5) | 1168919 |
| f | Balance at the end of the current year (subtract line **7e(5)** from line **7d**) | | | 7f | 4539357 |

## 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. ▶

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

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

**A** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**B** Three-digit plan number (PN) ▶ 001

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORTH COUNTRY HEALTH SYSTEM, INC.

**D** Employer Identification Number (EIN)
03-0185556

## Part I Service Provider Information (see instructions)

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

### 1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

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

CHARLES SCHWAB & CO., INC.

94-1737782

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

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

**(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)

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

| (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 28 37 38 50 54 59 61 62 63 64 65 | RECORD KEEPER | 80193 | Yes [X] No [ ] | Yes [X] No [ ] | 0 | Yes [X] No [ ] |

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

NATIONAL FINANCIAL SERVICES

04-3523567

| (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? |
|---|---|---|---|---|---|---|
| 33 71 | SECURITIES BROKER | 0 | Yes [X] No [ ] | Yes [ ] No [X] | 0 | Yes [X] No [ ] |

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

CHARLES SCHWAB & CO., INC.

94-1737782

| (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? |
|---|---|---|---|---|---|---|
| 33 71 | SECURITIES BROKER | 0 | Yes [X] No [ ] | Yes [X] No [ ] | 0 | Yes [X] No [ ] |

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

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

CAPFINANCIAL PARTNERS, LLC

20-4668732

| (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? |
|---|---|---|---|---|---|---|
| 16 23 53 | ADVISOR | 76634 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

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

FORVIS MAZARS

44-0160260

| (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 50 | AUDITOR | 19425 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

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

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

## Part I Service Provider Information (continued)

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

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| BLACKROCK<br>40 EAST 52ND ST<br>NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| CARILLON<br>880 CARILLON PARKWAY<br>ST. PETERSBURG, FL 33716 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| COHEN & STEERS<br>280 PARK AVENUE<br>NEW YORK, NY 10017 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| FIDELITY<br>100 CROSBY PARKWAY<br>COVINGTON, KY 41015 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| MFS<br>111 HUNTINGTON AVE<br>BOSTON, MA 02199 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| PARNASSUS<br>1 MARKET ST. STE 1600<br>SAN FRANCISCO, CA 94105 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| PIMCO<br>650 NEWPORT CENTER DR<br>NEWPORT BEACH, CA 92660 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| ROBECO INVESTMENT MANAGEMENT<br>909 THIRD AVE<br>32ND FL<br>NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 12 15 28 37 38 50 54 59 61 62 63 64 65 | 0 |

| **(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. |
|---|---|
| VICTORY<br>3435 STELZER RD<br>COLUMBUS, OH 43219 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| BLACKROCK<br>40 EAST 52ND ST<br>NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| CARILLON<br>880 CARILLON PARKWAY<br>ST. PETERSBURG, FL 33716 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| COHEN & STEERS<br>280 PARK AVENUE<br>NEW YORK, NY 10017 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| FIDELITY<br>100 CROSBY PARKWAY<br>COVINGTON, KY 41015 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| MFS<br>111 HUNTINGTON AVE<br>BOSTON, MA 02199 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| PARNASSUS<br>1 MARKET ST. STE 1600<br>SAN FRANCISCO, CA 94105 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| PIMCO<br>650 NEWPORT CENTER DR<br>NEWPORT BEACH, CA 92660 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| ROBECO INVESTMENT MANAGEMENT<br>909 THIRD AVE<br>32ND FL<br>NEW YORK, NY 10022 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| NATIONAL FINANCIAL SERVICES | 33 71 | 0 |

| **(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. |
|---|---|
| VICTORY<br>3435 STELZER RD<br>COLUMBUS, OH 43219 | REVENUE SHARING SEE ATTACHMENT TO LINE 2(H) |

## 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 |
|---|---|---|
| CHARLES SCHWAB & CO, INC. | 33 71 | 0 |
| **(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. | |
| SCHWAB FUNDS<br><br>94-3106735 | RATE OF 0.25% OF AVERAGE DAILY BALANCE OF ASSET(S) | |

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

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

## Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

**a** Name:

**b** EIN:

**c** Position:

**d** Address:

**e** Telephone:

Explanation:

**a** Name:

**b** EIN:

**c** Position:

**d** Address:

**e** Telephone:

Explanation:

**a** Name:

**b** EIN:

**c** Position:

**d** Address:

**e** Telephone:

Explanation:

**a** Name:

**b** EIN:

**c** Position:

**d** Address:

**e** Telephone:

Explanation:

**a** Name:

**b** EIN:

**c** Position:

**d** Address:

**e** Telephone:

Explanation:

# SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Financial Information

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

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

OMB No. 1210-0110

**2025**

**This Form is Open to Public Inspection**

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

**A** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**B** Three-digit plan number (PN) ▶ 001

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORTH COUNTRY HEALTH SYSTEM, INC.

**D** Employer Identification Number (EIN)
03-0185556

## Part I Asset and Liability Statement

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

| Assets | | (a) Beginning of Year | (b) End of Year |
|---|---|---|---|
| **a** Total noninterest-bearing cash | 1a | | |
| **b** Receivables (less allowance for doubtful accounts): | | | |
| **(1)** Employer contributions | 1b(1) | 216627 | 225695 |
| **(2)** Participant contributions | 1b(2) | | |
| **(3)** Other | 1b(3) | 3937 | 3895 |
| **c** General investments: | | | |
| **(1)** Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | | |
| **(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) | 238317 | 287272 |
| **(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) | 67129908 | 77247241 |
| **(14)** Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | 5006444 | 4597834 |
| **(15)** Other | 1c(15) | 1359128 | 1593700 |

| | | (a) Beginning of Year | (b) End of Year |
|---|---|---|---|
| **1d** Employer-related investments: | | | |
| **(1)** Employer securities | 1d(1) | | |
| **(2)** Employer real property | 1d(2) | | |
| **1e** Buildings and other property used in plan operation | 1e | | |
| **1f** Total assets (add all amounts in lines 1a through 1e) | 1f | 73954361 | 83955637 |
| **Liabilities** | | | |
| **1g** Benefit claims payable | 1g | | |
| **1h** Operating payables | 1h | | |
| **1i** Acquisition indebtedness | 1i | | |
| **1j** Other liabilities | 1j | | |
| **1k** Total liabilities (add all amounts in lines 1g through1j) | 1k | | |
| **Net Assets** | | | |
| **1l** Net assets (subtract line 1k from line 1f) | 1l | 73954361 | 83955637 |

## 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) | 1972722 | |
| **(B)** Participants | 2a(1)(B) | 3253583 | |
| **(C)** Others (including rollovers) | 2a(1)(C) | 177561 | |
| **(2)** Noncash contributions | 2a(2) | | |
| **(3)** Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)** | 2a(3) | | 5403866 |
| **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) | 17126 | |
| **(F)** Other | 2b(1)(F) | 137134 | |
| **(G)** Total interest. Add lines **2b(1)(A)** through **(F)** | 2b(1)(G) | | 154260 |
| **(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) | 1396015 | |
| **(D)** Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)** | 2b(2)(D) | | 1396015 |
| **(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) | | |
| **(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) | | 9948692 |
| c Other income | 2c | | 177836 |
| d Total income. Add all **income** amounts in column (b) and enter total | 2d | | 17080669 |
| **Expenses** | | | |
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 6884024 | |
| (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) | | 6884024 |
| f Corrective distributions (see instructions) | 2f | | 7140 |
| g Certain deemed distributions of participant loans (see instructions) | 2g | | 11977 |
| h Interest expense | 2h | | |
| i Administrative expenses: | | | |
| (1) Salaries and allowances | 2i(1) | | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Recordkeeping fees | 2i(3) | 80193 | |
| (4) IQPA audit fees | 2i(4) | 19425 | |
| (5) Investment advisory and investment management fees | 2i(5) | 76634 | |
| (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) | | 176252 |
| j Total expenses. Add all **expense** amounts in column (b) and enter total | 2j | | 7079393 |
| **Net Income and Reconciliation** | | | |
| k Net income (loss). Subtract line **2j** from line **2d** | 2k | | 10001276 |
| l Transfers of assets: | | | |
| (1) To this plan | 2l(1) | | |
| (2) From this plan | 2l(2) | | |

## Part III Accountant's Opinion

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

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

**(1)** [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

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

**(1)** [X] 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: FORVIS MAZARS, LLP **(2)** EIN: 44-0160260

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

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

## Part IV Compliance Questions

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

During the plan year:

| | | Yes | No | Amount |
|---|---|---|---|---|
| **a** Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) | **4a** | | X | |
| **b** Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) | **4b** | | X | |
| **c** Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) | **4c** | | X | |
| **d** Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) | **4d** | | X | |
| **e** Was this plan covered by a fidelity bond? | **4e** | X | | 1000000 |
| **f** Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | **4f** | | X | |
| **g** Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? | **4g** | | X | |
| **h** Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | **4h** | | X | |
| **i** Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | **4i** | X | | |
| **j** Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) | **4j** | | X | |
| **k** Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | **4k** | | X | |
| **l** Has the plan failed to provide any benefit when due under the plan? | **4l** | | X | |
| **m** If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | **4m** | | X | |
| **n** If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. | **4n** | | X | |

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

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

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

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

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

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

# SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Retirement Plan Information

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

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

OMB No. 1210-0110

**2025**

**This Form is Open to Public Inspection.**

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

**A** Name of plan
NORTH COUNTRY HEALTH SYSTEM, INC. CONTRIBUTORY TAX SHELTERED RETIREMENT PLAN

**B** Three-digit plan number (PN) ▶ 001

**C** Plan sponsor's name as shown on line 2a of Form 5500
NORTH COUNTRY HEALTH SYSTEM, INC.

**D** Employer Identification Number (EIN)
03-0185556

## 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): 13-3689044

**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** 109

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

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

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

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

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

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

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

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

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

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

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

## Part III Amendments

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

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

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

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

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

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

## Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

**a** Name of contributing employer

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

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

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

---

**a** Name of contributing employer

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

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

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

---

**a** Name of contributing employer

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

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

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

---

**a** Name of contributing employer

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

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

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

---

**a** Name of contributing employer

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

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

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

---

**a** Name of contributing employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Yes.

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

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

☐ No. Other. Provide explanation._____

## Part VII IRS Compliance Questions

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

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

☐ Design-based safe harbor method

☐ "Prior year" ADP test

☐ "Current year" ADP test

☒ N/A

**22** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 03 / 31 / 2017 (MM/DD/YYYY) and the Opinion Letter serial number J500863A .

# North Country Health System, Inc. Contributory Tax Sheltered Retirement Plan

## EIN 03-0185556 PN 001

## Independent Auditor's Report, Financial Statements and Supplemental Schedule

December 31, 2025 and 2024

**North Country Health System, Inc.**
**Contributory Tax Sheltered Retirement Plan**
**Contents**
**December 31, 2025 and 2024**


**Independent Auditor's Report** ..... 1

**Financial Statements**

Statements of Net Assets Available for Benefits ..... 5

Statements of Changes in Net Assets Available for Benefits ..... 6

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**Supplemental Schedule**

Schedule H, Line 4i – Schedule of Assets (Held at End of Year) as of December 31, 2025 ..... 16

Forvis Mazars, LLP
910 E. St. Louis Street
Springfield, MO 65806
P 417.865.8701 | F 417.865.0682
forvismazars.us

# Independent Auditor's Report

Plan Administrator and Retirement Plan Committee
North Country Health System, Inc. Contributory Tax
Sheltered Retirement Plan
Newport, Vermont

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

We have performed audits of the financial statements of North Country Health System, Inc. Contributory Tax Sheltered Retirement 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, 2025 and 2024, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audits of North Country Health System, Inc. Contributory Tax Sheltered Retirement 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, 2025 and 2024, and for the years then ended, stating that the certified investment information, as described in Note 3 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 Auditor's Responsibilities for the Audit of the Financial Statements section:

- The amounts and disclosures in the accompanying financial statements, 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 accompanying financial statements 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 (GAAS). 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 North Country Health System, Inc. Contributory Tax Sheltered Retirement 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 North Country Health System, Inc. Contributory Tax Sheltered Retirement Plan's ability to continue as a going concern within one year after the date that these financial statements are available to be issued.

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

## *Auditor's Responsibilities for the Audit of the Financial Statements*

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 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 GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the North Country Health System, Inc. Contributory Tax Sheltered Retirement Plan's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the North Country Health System, Inc. Contributory Tax Sheltered Retirement 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 Matter – Supplemental Schedule Required by ERISA*

The supplemental schedule listed in the table of contents is presented for purposes of additional analysis and is not a required part of the financial statements but is 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 schedule, 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 GAAS. For information included in the supplemental schedule 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 schedule, we evaluated whether the supplemental schedule, other than the information agreed to or derived from the certified investment information, including its form and content, is 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 schedule, other than the information in the supplemental schedule 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 schedule 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).

Forvis Mazars, LLP

**Springfield, Missouri**
**September 23, 2026**

Federal Employer Identification Number: 44-0160260

**North Country Health System, Inc.**
**Contributory Tax Sheltered Retirement Plan**
**Statements of Net Assets Available for Benefits**
**December 31, 2025 and 2024**

| | 2025 | 2024 |
|---|---|---|
| **ASSETS** | | |
| **Investments** | | |
| At fair value | $ 78,840,941 | $ 68,489,036 |
| At contract value | 4,597,834 | 5,006,444 |
| **Total Investments** | 83,438,775 | 73,495,480 |
| **Receivables** | | |
| Employer contribution | 225,695 | 216,627 |
| Notes receivable from participants | 377,068 | 329,437 |
| Accrued interest on notes receivable from participants | 3,895 | 3,937 |
| **Total Receivables** | 606,658 | 550,001 |
| **Net Assets Available for Benefits** | $ 84,045,433 | $ 74,045,481 |

**North Country Health System, Inc.**
**Contributory Tax Sheltered Retirement Plan**
**Statements of Changes in Net Assets Available for Benefits**
**Years Ended December 31, 2025 and 2024**

| | 2025 | 2024 |
|---|---|---|
| **Additions** | | |
| **Investment Income** | | |
| Net appreciation in fair value of investments | $ 10,126,526 | 8,305,915 |
| Interest | 137,134 | 138,297 |
| Dividends | 1,396,015 | 1,225,575 |
| **Net Investment Income** | 11,659,675 | 9,669,787 |
| **Interest Income on Notes Receivable from Participants** | 17,126 | 10,610 |
| **Contributions** | | |
| Employer | 1,972,722 | 1,897,018 |
| Participants | 3,253,583 | 3,098,363 |
| Rollovers | 177,561 | 10,554 |
| | 5,403,866 | 5,005,935 |
| **Total Additions** | 17,080,667 | 14,686,332 |
| **Deductions** | | |
| Benefits paid to participants | 6,904,463 | 7,773,764 |
| Administrative expenses | 176,252 | 133,085 |
| **Total Deductions** | 7,080,715 | 7,906,849 |
| **Net Increase** | 9,999,952 | 6,779,483 |
| **Net Assets Available for Benefits, Beginning of Year** | 74,045,481 | 67,265,998 |
| **Net Assets Available for Benefits, End of Year** | $ 84,045,433 | $ 74,045,481 |

## Note 1. Description of the Plan

### *General*

The following description of North Country Health System, Inc. Contributory Tax Sheltered Retirement Plan (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 a defined contribution plan sponsored by North Country Health System, Inc. (Health System) for the benefit of its employees. Employees are immediately eligible to participate in the Plan as a contributing participant upon commencement of employment with the Health System. A related employer who also participates in the Plan is North Country Health Services, Inc.

The Plan is subject to the provisions of the *Employee Retirement Income Security Act of 1974* (ERISA). Transamerica Financial Life Insurance Company (TFLIC) and Transamerica Life Insurance Company (Transamerica) serve as custodians of the Plan. Transamerica serves as the issuer of the guaranteed investment contract held by the Plan and is the recordkeeper of the Plan. State Street Bank and Trust Company serves as Plan Custodian.

### *Contributions*

The Plan permits eligible employees to have the Health System make annual contributions through a salary deferral election, which may be no more than the legal limits. These contributions are made on a pretax basis subject to the rules contained in the Internal Revenue Code (IRC). Contributions are subject to certain limitations. Employee rollover contributions are also permitted. Participants who have attained age 50 before the end of the plan year are eligible to make catch-up contributions. The Plan permits participants to make Roth 403(b) deferrals to the Plan and allows direct rollovers from other qualified Roth contribution programs described in Code Section 402A. The Health System makes matching contributions of 50% of employees' salary deferral amounts up to 5.0% of an employees' compensation deferral, not to exceed 2.5% of compensation. The Health System may also make a discretionary base contribution for employees who are over the age of 21 with more than two years of service who are employed at the end of the plan year quarter. These contributions correlate to the number of years of service an employee has contributed. Effective January 1, 2025, the Plan was amended to elect that nonelective employer contributions will be made for a plan year quarter for any participant who retires during the plan year quarter, if the participant is at the normal retirement age. During 2025 and 2024, the Health System made discretionary base contributions of $1,039,599 and $1,263,588, respectively.

### *Participant Investment Account Options*

Investment account options available include various funds. Each participant has the option of directing contributions into any of the investment accounts selected by the Health System and may change the allocation to the extent permitted by the individual agreements. Participants also have the option to individually direct their investments as they choose within a separate account.

The Plan Document also includes an automatic deferral feature whereby a participant hired on or after January 1, 2010 is treated as electing to defer a certain percentage of eligible compensation unless the participant made an affirmative election otherwise. The automatic deferral feature also provides for an annual increase in the percentage deferred and is ultimately capped at 10%.

### *Participant Accounts*

Each participant's account is credited with the participant's contribution, the Health System's contribution, and plan earnings and is charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

### *Vesting*

Participants are immediately vested in their voluntary contributions and Health System's nonelective contributions and matching contributions plus earnings thereon.

### *Notes Receivable from Participants*

The Plan Document includes provisions authorizing loans from the Plan to eligible participants. Loans are made to any eligible participant demonstrating a qualifying need. The minimum amount of a loan shall be $1,000. The maximum amount of a participant's loan is determined by the available loan balance restricted to the lesser of $50,000 or 50% of the participant's vested account balance. The loan interest rate is set at the Prime Rate plus 1%. All loans are covered by demand notes and are repayable over a period not to exceed five years (except for loans for the purchase of a principal residence) through payments made quarterly by the participant directly to Transamerica unless the participant is paying the loan in full.

### *Payment of Benefits*

Upon termination of service, vested participants with account balances that do not exceed $1,000 will receive a lump-sum distribution. Vested participants with account balances exceeding $1,000 but not exceeding $5,000 will have their balance directly rolled over to an individual retirement account as designated by the Plan Administrator, absent an election by the participant. Participants with account balances exceeding $5,000 may elect to receive a lump-sum distribution equal to their vested value. Withdrawals other than for termination are permitted under circumstances provided by the Plan.

## Note 2. Summary of Significant Accounting Policies

### *Basis of Accounting*

The accompanying financial statements are prepared on the accrual basis of accounting.

### *Use of Estimates*

The preparation of financial statements in conformity 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, changes in net assets, and the disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

### *Investment Valuation and Income Recognition*

Investments are reported at fair value (except for fully benefit-responsive investment contracts, which are reported at contract value). Quoted market prices, if available, are used to value investments. Mutual funds are valued at the net asset value (NAV) of shares held by the Plan at year-end.

The Schwab Personal Choice Retirement Account (PCRA) holds investments which are not standard options of the Plan as directed by participants. Mutual funds and the money market mutual funds held in the PCRA account are valued at the NAV of shares held by the Plan at year-end.

Investment contracts held by a defined contribution plan are required to be reported at fair value, except for fully benefit responsive investment contracts, which are reported at contract value. Contract value is the relevant measure for the portion of net assets available for benefits attributable to fully benefit responsive investment contracts because contract value is the amount participants normally would receive if they were to initiate permitted transactions under the terms of the Plan. Contract value represents contributions made under the contract, plus interest at the contract rate, less participant withdrawals and administrative expenses.

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

### *Contributions*

Contributions from Plan participants and the matching contributions from the Health System are recorded in the year in which the employee contributions are withheld from compensation.

### *Notes Receivable from Participants*

Notes receivable from participants are reported at their unpaid principal balance plus any accrued but unpaid interest. Delinquent participant loans are reclassified as distributions based upon the terms of the Plan Document.

### *Payment of Benefits*

Benefit payments to participants are recorded upon distribution.

### *Administrative Expenses*

Administrative expenses may be paid by the Health System or the Plan, at the Health System's discretion.

The Plan has a nonallocated expense budget account held in a TFLIC stable general account. The purpose of this account is to pay necessary and reasonable plan expenses in accordance with the Department of Labor's guidance. The Health System is responsible for determining what expenses the third-party administrator will reimburse from the account. All funds utilized from this account are treated as administrative expenses on the statements of changes in net assets available for benefits. During 2025 and 2024, additions (reductions) to the account were ($36,076) and $113,978, respectively. The expense budget account funds utilized during 2025 and 2024 to pay administrative expenses totaled $96,378 and $82,451, respectively. The account's balance at December 31, 2025 and 2024, was $47,202 and $177,846, respectively.

## Note 3. Certification of Plan Custodians

The Plan Administrator has elected the method of annual reporting compliance permitted by 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. Accordingly, State Street Bank and Trust Company, TFLIC, and Transamerica, qualifying institutions, have certified the following information included in the accompanying financial statements and ERISA-required supplemental schedule is complete and accurate:

- Investments and notes receivable from participants as shown in the statements of net assets available for benefits as of December 31, 2025 and 2024.

- Investment income and interest income from notes receivable from participants as shown in the statements of changes in net assets available for benefits for the years ended December 31, 2025 and 2024.

- Investment information and notes receivable from participants included in the accompanying schedule of assets (held at year-end) as of December 31, 2025.

The Plan's independent auditors did not perform auditing procedures with respect to this certified information, except for comparing such certified information to the related investment information included in the financial statements and ERISA-required supplemental schedule.

## Note 4. Party-in-Interest Transactions

Party-in-interest transactions include those with fiduciaries or employees of the Plan, any person who provides services to the Plan, an employer whose employees are covered by the Plan, an employee organization whose members are covered by the Plan, a person who owns 50% or more of such an employer or employee association, or relatives of such persons.

Certain Plan investments are units of guaranteed investment accounts and a general account managed by TFLIC or Transamerica, which are custodians as defined by the plan agreement. Therefore, these transactions qualify as party-in-interest transactions.

The Plan paid $80,193 and $50,634 of recordkeeping fees to Transamerica Retirement Solutions, LLC during 2025 and 2024, respectively.

The Health System provides certain administrative services at no cost to the Plan.

## Note 5. Disclosures About Fair Value of Plan Assets and Liabilities

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. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. The hierarchy comprises three levels of inputs that may be used to measure fair value:

**Level 1** Quoted prices in active markets for identical assets.

**Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

**Level 3** Unobservable inputs supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

### *Recurring Measurements*

The following tables present the fair value measurements of assets recognized in the accompanying statements of net assets available for benefits measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31, 2025 and 2024:

| | 2025 | | | |
|---|---|---|---|---|
| | Fair Value Measurements Using | | | |
| | Fair Value | Quoted Prices in Active Markets for Identical Assets (Level 1) | Significant Other Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) |
| **December 31, 2025** | | | | |
| Mutual funds | $ 77,247,241 | $ 77,247,241 | $ - | $ - |
| Schwab Personal Choice Retirement Account | 1,593,700 | 1,593,700 | - | - |
| | $ 78,840,941 | $ 78,840,941 | $ - | $ - |

| | 2024 Fair Value Measurements Using | | | |
|---|---|---|---|---|
| | Fair Value | Quoted Prices in Active Markets for Identical Assets (Level 1) | Significant Other Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) |
| **December 31, 2024** | | | | |
| Mutual funds | $ 67,129,908 | $ 67,129,908 | $ - | $ - |
| Schwab Personal Choice Retirement Account | 1,359,128 | 1,359,128 | - | - |
| | $ 68,489,036 | $ 68,489,036 | $ - | $ - |

Following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the accompanying statements of net assets available for benefits, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended December 31, 2025 and 2024. The Plan had no liabilities measured at fair value on a recurring basis. In addition, the Plan had no assets or liabilities measured at fair value on a nonrecurring basis.

### *Investments*

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections and cash flows. Such securities are classified in Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

## Note 6. Investment Contracts with Insurance Companies

### *Stable General Account*

The Plan is invested in an investment contract with TFLIC, in which advance employer contributions to the Plan as well as additions into the employer expense budget account are credited to an unallocated fund established under a group annuity contract. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate guaranteed to the Plan.

The guaranteed investment contract is fully benefit responsive; therefore, contract value is the relevant measurement. Contract value, as reported to the Plan by TFLIC, represents contributions made under the contract, plus earnings, less withdrawals and administrative expenses. The Plan may ordinarily direct the withdrawal or transfer of all or a portion of the investment at contract value.

There are no reserves against the contract value for credit risk of the contract issuer or otherwise.

The contract value of the Stable General Account at December 31, 2025 and 2024, was $58,477 and $188,857, respectively.

### *Guaranteed Investment Option*

The Plan is invested in a fully benefit responsive investment contract with Transamerica. Transamerica maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate guaranteed to the Plan.

The guaranteed investment contract is fully benefit responsive; therefore, contract value is the relevant measurement. Contract value, as reported to the Plan by Transamerica, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

There are no reserves against the contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but it may not be less than 1%. Such interest rates are reviewed on an annual basis for resetting.

Certain events may limit the ability of the Plan to transact at contract value with the issuer. Written notice must be provided before the contract will be suspended. Such events include the following: (1) contributions do not comply with the requirements of Section 403(b) of the Code or of ERISA; (2) contributions required by the contract have not been received by Transamerica; (3) plan assets no longer are in trust with Transamerica; (4) Transamerica will no longer be providing record-keeping and administrative services to the Plan; (5) Transamerica determines that it can no longer continue to provide benefits under the contract due to changes to the Plan; and (6) a violation of any provision of the contract. The Plan Administrator does not believe the occurrence of any such value event, which would limit the Plan’s ability to transact at contract value with participants, is probable.

The contract value of the Transamerica Guaranteed Investment Option at December 31, 2025 and 2024, is $4,539,357 and $4,817,587, respectively.

## Note 7. Reconciliation of Financial Statements to Form 5500

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

| | 2025 | 2024 |
|---|---|---|
| Net assets available for benefits per the financial statements | $ 84,045,433 | $ 74,045,481 |
| Less: Deemed loans | (89,796) | (91,120) |
| Net assets available for benefits per Form 5500 | $ 83,955,637 | $ 73,954,361 |

The following is a reconciliation of benefits paid to participants per the financial statements for the years ended December 31, 2025 and 2024, to Form 5500:

| | 2025 | 2024 |
|---|---|---|
| Benefits paid to participants per the financial statements | $ 6,904,463 | $ 7,773,764 |
| Change in deemed loans | (1,322) | (4,651) |
| Benefits paid directly to participants per Form 5500 | $ 6,903,141 | $ 7,769,113 |

## Note 8. 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 the participants' account balances and the amounts reported in the statements of net assets available for benefits.

## Note 9. Plan Termination

Although it has not expressed an intention to do so, the Health System has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA.

## Note 10. Tax Status

The Plan, together with the investment vehicles, is intended to be a tax-sheltered annuity plan under Section 403(b) of the Internal Revenue Code of 1986, as amended. The Plan operates under a volume submitter agreement in connection with a volume submitter plan and custodial document sponsored by Transamerica Retirement Solutions, LLC. This volume submitter plan document has obtained an advisory letter from the IRS stating that the volume submitter satisfies the requirements under Section 403(b) of the Internal Revenue Code (IRC). Although the Plan has been amended since the volume submitter plan document received the advisory letter, the Plan Administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC and, therefore, the Plan is qualified.

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 is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress

## Note 11. Subsequent Events

Subsequent events have been evaluated through September 23, 2026, which is the date the financial statements were available to be issued.

Effective July 16, 2026, the Plan was amended to incorporate certain provisions of the SECURE 2.0 Act, including increasing the required minimum distribution age to 72, applying the 10-year distribution rule for designated beneficiaries, and permitting qualified birth and adoption distributions, including the recontribution of such distributions. As a result of the amendment, the Plan Sponsor adopted a restated Plan document incorporating the applicable SECURE 2.0 provisions, effective January 1, 2026.

# *Supplemental Schedule*

**North Country Health System, Inc.**
**Contributory Tax Sheltered Retirement Plan**
**EIN 03-0185556 PN 001**
**Schedule H, Line 4i – Schedule of Assets (Held at End of Year)**
**December 31, 2025**

| | Identity of Issuer | Description of Investment | Current Value |
|---|---|---|---|
| | **Mutual Funds** | | |
| | Blackrock | BlackRock Eq Dividend I | $ 2,399,463 |
| | Blackrock | BlackRock High Yield Portfolio K | 820,212 |
| | Eagle | Carillon Eagle Mid Cap Gr R6 | 156,717 |
| | Cohen & Steers | Cohen & Steers Instl Realty Shares | 461,383 |
| | Fidelity | Fidelity Contrafund K6 | 9,127,776 |
| | Fidelity | Fidelity Extended Market Index | 2,720,333 |
| | Fidelity | Fidelity Total Intl Index | 3,060,167 |
| | Fidelity | Fidelity US Bd Index | 2,127,154 |
| | JPMorgan | JPMorgan U.S. Small Co R6 | 1,018,210 |
| | MassMutual | MassMtl Small Cap Gr Eq I | 200,499 |
| | MFS | MFS Intl Diversification R6 | 1,505,920 |
| | MFS | MFS Mid Cap Val R6 | 193,308 |
| | Parnassus | Parnassus Core Eq Instl | 1,177,024 |
| | PIMCO | PIMCO Total Return Instl | 650,624 |
| | Robeco Investment Management | Robeco Boston Partnrs Sm cpVal II I | 209,944 |
| | T. Rowe Price | T. Rowe Price Ret 2010 I | 132,846 |
| | T. Rowe Price | T. Rowe Price Ret 2015 I | 683,822 |
| | T. Rowe Price | T. Rowe Price Ret 2020 I | 338,372 |
| | T. Rowe Price | T. Rowe Price Ret 2025 I | 2,272,597 |
| | T. Rowe Price | T. Rowe Price Ret 2030 I | 9,809,578 |
| | T. Rowe Price | T. Rowe Price Ret 2035 I | 5,915,937 |
| | T. Rowe Price | T. Rowe Price Ret 2040 I | 9,267,961 |
| | T. Rowe Price | T. Rowe Price Ret 2045 I | 2,271,818 |
| | T. Rowe Price | T. Rowe Price Ret 2050 I | 4,985,506 |
| | T. Rowe Price | T. Rowe Price Ret 2055 I | 3,295,582 |
| | T. Rowe Price | T. Rowe Price Ret 2060 I | 1,942,594 |
| | Vanguard | Vanguard Federal Money Market | 340,358 |
| | Vanguard | Vanguard Inf-Protected Secs Adm | 517,366 |
| | Vanguard | Vanguard Instl Index | 9,644,170 |
| | | **Mutual Funds Total** | 77,247,241 |
| | **Insurance Company/General Account** | | |
| * | Transamerica Financial Life Ins. Co. | Stable General Account | 58,477 |
| * | Transamerica Life Ins. Co. | Guaranteed Investment Option | 4,539,357 |
| | | **Insurance Company/General Account Total** | 4,597,834 |
| | Charles Schwab Institutional | Personal Choice Retirement Account (Other Funds) | 1,593,700 |
| * | Participants | Notes receivable with an interest rate of 4.25% to 9.5% | 287,272 |
| | Total plan assets | | $ 83,726,047 |

* Indicates party-in-interest to the Plan as defined by ERISA

# Schedule C, Line 2(h) Formula Descriptions

**North Country Health System, Inc. Contributory Tax-Sheltered Retirement Plan**
**EIN No.: 03-0185556, Plan No. 001**
**Plan Year Ending: 12/31/2025**

**Indirect Compensation in the form of revenue sharing was paid to the following Service Providers:**

| | |
|---|---|
| TRANSAMERICA RETIREMENT SOLUTIONS | 13-3689044 |
| NATIONAL FINANCIAL SERVICES | 04-3523567 |

Revenue amounts are shown in annualized basis points of plan assets invested in applicable fund

| Fund Family | Fund Name | Start Date | End Date | Revenue to Transamerica Retirement Solutions | Revenue to National Financial Services |
|---|---|---|---|---|---|
| BLACKROCK | BLACKROCK EQUITY DIVIDEND, I | 1/1/2025 | 12/31/2025 | 24.175 | 0.825 |
| BLACKROCK | BLACKROCK HIGH YIELD PORTFOLIO INSTL | 1/1/2025 | 6/11/2025 | 14.505 | 0.495 |
| CARILLON | CARILLON EAGLE MID CAP GROWTH I | 1/1/2025 | 6/11/2025 | 14.505 | 0.495 |
| COHEN & STEERS | COHEN & STEERS REALTY SHARES | 1/1/2025 | 6/11/2025 | 43.515 | 1.485 |
| COHEN & STEERS | COHEN AND STEERS INSTL REALTY | 6/11/2025 | 12/31/2025 | 9.670 | 0.330 |
| FIDELITY | FIDELITY CONTRAFUND | 1/1/2025 | 6/11/2025 | 24.175 | 0.825 |
| MFS | MFS INTL DIVERSIFICATION R3 | 1/1/2025 | 6/11/2025 | 48.350 | 1.650 |
| MFS | MFS MID CAP VALUE R3 | 1/1/2025 | 6/11/2025 | 48.350 | 1.650 |
| PARNASSUS | PARNASSUS CORE EQUITY INSTL | 1/1/2025 | 12/31/2025 | 9.670 | 0.330 |
| PIMCO | PIMCO TOTAL RETURN, CLASS A | 1/1/2025 | 6/11/2025 | 43.515 | 1.485 |
| ROBECO INVESTMENT MANAGEMENT | ROBECO BOSTON PARTNRS SMCAPVAL | 12/11/2025 | 12/31/2025 | 14.505 | 0.495 |
| VICTORY | VICTORY SYCAMORE SMALL COMPANY OPPORTUNITY I | 1/1/2025 | 6/11/2025 | 9.670 | 0.330 |

**North Country Health System, Inc. Contributory Tax-Sheltered Retirement Plan**
**EIN No.: 03-0185556, Plan No. 001**
**Schedule H, Line 4i - Schedule of Assets**
**Plan Year Ending: 12/31/2025**

| (a) | (b) Identity of Issuer, Borrower, Lessor or Similar Party | (c) Description of Investment, Including Maturity Date, Rate of Interest, Par or Maturity Value | (d) CURRENT VALUE |
|---|---|---|---|
| * | Transamerica Financial Life Ins. Co. | TFLIC Stable | $ 58,477 |
| * | Transamerica Life Ins Co | Transamerica Guaranteed Inv Option | $ 4,539,357 |
| | | **General Insurance Accounts Total** | **$ 4,597,834** |
| | Blackrock | BlackRock Eq Dividend I | $ 2,399,463 |
| | Blackrock | BlackRock High Yield Portfolio K | $ 820,212 |
| | Eagle | Carillon Eagle Mid Cap Gr R6 | $ 156,717 |
| | Cohen & Steers | Cohen & Steers Instl Realty Shares | $ 461,383 |
| | Fidelity | Fidelity Contrafund K6 | $ 9,127,776 |
| | Fidelity | Fidelity Extended Market Index | $ 2,720,333 |
| | Fidelity | Fidelity Total Intl Index | $ 3,060,167 |
| | Fidelity | Fidelity US Bd Index | $ 2,127,154 |
| | JPMorgan | JPMorgan U.S. Small Co R6 | $ 1,018,210 |
| | MassMutual | MassMtl Small Cap Gr Eq I | $ 200,499 |
| | MFS | MFS Intl Diversification R6 | $ 1,505,920 |
| | MFS | MFS Mid Cap Val R6 | $ 193,308 |
| | Parnassus | Parnassus Core Eq Instl | $ 1,177,024 |
| | PIMCO | PIMCO Total Return Instl | $ 650,624 |
| | Robeco Investment Management | Robeco Boston Partnrs Sm cpVal II I | $ 209,944 |
| | T. Rowe Price | T. Rowe Price Ret 2010 I | $ 132,846 |
| | T. Rowe Price | T. Rowe Price Ret 2015 I | $ 683,822 |
| | T. Rowe Price | T. Rowe Price Ret 2020 I | $ 338,372 |
| | T. Rowe Price | T. Rowe Price Ret 2025 I | $ 2,272,597 |
| | T. Rowe Price | T. Rowe Price Ret 2030 I | $ 9,809,578 |
| | T. Rowe Price | T. Rowe Price Ret 2035 I | $ 5,915,937 |
| | T. Rowe Price | T. Rowe Price Ret 2040 I | $ 9,267,961 |
| | T. Rowe Price | T. Rowe Price Ret 2045 I | $ 2,271,818 |
| | T. Rowe Price | T. Rowe Price Ret 2050 I | $ 4,985,506 |
| | T. Rowe Price | T. Rowe Price Ret 2055 I | $ 3,295,582 |
| | T. Rowe Price | T. Rowe Price Ret 2060 I | $ 1,942,594 |
| | Vanguard | Vanguard Federal Money Market | $ 340,358 |
| | Vanguard | Vanguard Inf-Protected Secs Adm | $ 517,366 |
| | Vanguard | Vanguard Instl Index | $ 9,644,170 |
| | | **Mutual Funds Total** | **$ 77,247,241** |
| | Charles Schwab Institutional | Personal Choice Retirement Account (Other Funds) | $ 1,593,700 |
| | | **Other Fund Total** | **$ 1,593,700** |
| * | Participants | Notes Receivable with interest rates of 4.25% to 9.50% | **$ 287,272** |
| | | **TOTAL PLAN ASSETS** | **$ 83,726,047** |

* Indicates Party-In-Interest to the Plan