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

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of 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)

Part II Basic Plan Information—enter all requested information

1a Name of plan
STINK, INC. HEALTH PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/2015

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)
STINK, INC.

420 COLUMBUS AVENUE
SAN FRANCISCO, CA 94133

2b Employer Identification Number (EIN) 94-3136988

2c Plan Sponsor's telephone number 415-781-7673

2d Business code (see instructions) 722511

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.	10/02/2021	DANTE SERAFINI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.		
	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:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	431
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)**	431
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	62
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	62
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	62
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4D 4Q

9a Plan funding arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	Trust
(4)	[ ]	General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	Trust
(4)	[ ]	General assets of the sponsor

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

a Pension Schedules

(1)	[ ]	**R** (Retirement Plan Information)
(2)	[ ]	**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)	[ ]	**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)	[X]		**H** (Financial Information)
(2)	[ ]		**I** (Financial Information – Small Plan)
(3)	[X]	2	**A** (Insurance Information)
(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 2020 Form M-1 annual report. If the plan was not required to file the 2020 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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
STINK, INC. HEALTH PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
STINK, INC.

D Employer Identification Number (EIN)
94-3136988

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
AETNA 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
06-6033492	60054	GP-499914	138	01/01/2020	12/31/2020

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
65549	

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

HEFFERNAN INSURANCE BROKERS
1350 CARLBACK AVE
WALNUT CREEK, CA 94596

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
23135			3

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

THE BOON INSURANCE AGENCY
6300 BRIDGEPOINT PARKWAY
AUSTIN, TX 78730

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
42414			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [X] 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** [X] Other (specify) ▶ AD&D

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**	385585
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

SCHEDULE 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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
STINK, INC. HEALTH PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
STINK, INC.

D Employer Identification Number (EIN)
94-3136988

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
GERBER 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
13-2611847	70939	SGGS1007-2020R4	125	01/01/2020	12/30/2020

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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

(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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

(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**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] 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** [X] Other (specify) ▶ SPEC/AGG STOP LOSS

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**	61383
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2020** **This Form is Open to Public Inspection.**

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
STINK, INC. HEALTH PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
STINK, INC.

D Employer Identification Number (EIN)
94-3136988

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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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)

BOON ADMINISTRATIVE SERVICES, INC.

33-0449333

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 73 50	NONE	152507	Yes [X] No [ ]	Yes [ ] No [X]	77117	Yes [ ] No [X]

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

THE BOON INSURANCE AGENCY

74-2236168

(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?
22 53	MARKETING AGENT	39962	Yes [ ] No [X]	Yes [ ] No [ ]	0	Yes [ ] No [ ]

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

FIRST HEALTH GROUP

20-1736437

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	7258	Yes [ ] No [X]

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)

ACTIVE HEALTH

52-2182411

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	7256	Yes [ ] No [X]

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

HEALTHIEST YOU

46-1345569

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	9537	Yes [ ] No [X]

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

WITHUMSMITH+BROWN, PC

22-2027092

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	17303	Yes [ ] No [X]

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)

HEFFERNAN INSURANCE BROKERS

1350 CARLBACK AVE
WALNUT CREEK, CA 94596

(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?
53	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	21172	Yes [ ] No [X]

(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 [ ]

(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
BOON ADMINISTRATIVE SERVICES, INC	12 13 62	

(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.
AETNA LIFE INSURANCE COMPANY 06-6033492	TOTAL ANNUAL PLAN PREMIUMS / TOTAL ANNUAL PLAN PREMIUMS FOR ALL PLANS X TOTAL ANNUAL INTEREST EARNED ON BANK ACCT = FLOAT REV. EARNED. TOTAL FLOAT INCOME EARNED < $10.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
BOON ADMINISTRATIVE SERVICES, INC	12 13 73	77117

(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.
AETNA LIFE INSURANCE COMPANY 06-6033492	BOON ADMINISTRATIVE SERVICES IS CONTRACTED WITH AETNA TO PROVIDE 3RD PARTY ADMIN SERVICES FOR THE PLAN. BOON ADMIN. SERVICES IS PAID FROM GENERAL ASSETS OF AETNA.

(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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
STINK, INC. HEALTH PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
STINK, INC.

D Employer Identification Number (EIN)
94-3136988

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 reported on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	210381	7065
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)		
(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)	2002177	1878306
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	**(b)** End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	2212558	1885371
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	145510	4844
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	145510	4844
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	2067048	1880527

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)	366506	
	(B) Participants	2a(1)(B)	324	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		366830
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		
	(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)	4907	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		4907
	(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)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		371737
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	23901	
(2) To insurance carriers for the provision of benefits	2e(2)	353947	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		377848
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	123521	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	56889	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		180410
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		558258
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-186521
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [ ] Unmodified **(2)** [ ] Qualified **(3)** [X] 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: WITHUMSMITH+BROWN, PC. **(2)** EIN: 22-2027092

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, 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.

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	

			Yes	No	Amount
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		206705
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l	Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ 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 _____.



STINK, INC. HEALTH PLAN
Financial Statements - Modified Cash Basis
December 31, 2020 and 2019
With Independent Auditor's Report

withum
ADVISORY TAX AUDIT

Stink, Inc. Health Plan
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December 31, 2020 and 2019

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Schedule H, Line 4j - Schedule of Reportable Transactions - Modified Cash Basis 12

withum
ADVISORY TAX AUDIT

INDEPENDENT AUDITOR'S REPORT

To the Plan Administrator,
Stink, Inc. Health Plan:

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Stink, Inc. Health Plan (the "Plan"), which comprise the statements of net assets available for benefits - modified cash basis as of December 31, 2020 and 2019, the related statement of changes in net assets available for benefits - modified cash basis for the year ended December 31, 2020 and the related notes to financial statements - modified cash basis.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in Note 2; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audits in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by Comerica Bank and Trust, N.A., the Trustee of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the Plan administrator that the Trustee holds the Plan's investments and executes investment transactions. The Plan administrator obtained a certification from the Trustee as of December 31, 2020 and 2019, and for the year ended December 31, 2020, that the information provided to the Plan administrator by the Trustee is complete and accurate.

Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the financial statements. Accordingly, we do not express an opinion on the accompanying financial statements.

Basis of Accounting

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matter

The supplemental schedule of assets (held at end of year) - modified cash basis and schedule of reportable transactions - modified cash basis as of and for the year ended December 31, 2020, are required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules.

Report on Form and Content in Compliance with DOL Rules and Regulations

The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the Trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

Wilkerson Smith + Brown, PC

September 28, 2021

Stink, Inc. Health Plan
Statements of Net Assets Available for Benefits - Modified Cash Basis
December 31, 2020 and 2019

	2020	2019
Assets		
Investments, at fair value	$ 1,878,306	$ 2,002,177
Receivables due from Boon Administrative Services, Inc.	7,065	210,381
Total assets	1,885,371	2,212,558
Liabilities		
Plan payables	4,844	145,510
Net assets available for benefits	$ 1,880,527	$ 2,067,048

The Notes to Financial Statements - Modified Cash Basis are an integral part of these statements.

Stink, Inc. Health Plan
Statement of Changes in Net Assets Available for Benefits - Modified Cash Basis
Year Ended December 31, 2020

Additions	
Additions to net assets attributed to	
Contributions	
Employer	$ 366,506
Participant	324
Total contributions	366,830
Dividend income	4,907
Total additions	371,737
Deductions	
Deductions from net assets attributed to	
Health care premiums payments	292,564
Health care claims paid	23,901
Stop-loss premium payments	61,383
Administrative expenses	180,410
Total deductions	558,258
Net change in net assets available for benefits	(186,521)
Net assets available for benefits	
Beginning of year	2,067,048
End of year	$ 1,880,527

The Notes to Financial Statements - Modified Cash Basis are an integral part of this statement.

1. DESCRIPTION OF PLAN

The Stink, Inc. Health Plan (the “Plan”) was established on January 1, 2015. The following description of the Plan provides only general information. Participants should refer to the associated Plan documents for a complete description of the Plan’s provisions. Stink, Inc. (the “Company” or “Plan Sponsor”) has the right to terminate, suspend, withdraw, or amend the Plan in whole or in part at any time, subject to the provisions set forth in the Employee Retirement Income Security Act of 1974 (“ERISA”).

The Stink, Inc. Employee Benefit Trust (the "Trust") was established on March 1, 2015, to fund employee health and welfare benefits under the Plan for the eligible employees of the Plan Sponsor, its affiliates and subsidiaries, and such employees' eligible dependents. The Trust is funded by irrevocable cash contributions paid by or at the direction of the Company or any eligible employer to be held, invested, reinvested, managed, administered, and distributed for the exclusive benefit of the participants. The Trust acts as the conduit for payment of claims, premiums, and other Plan expenses. The Company serves as Plan fiduciary and Plan Sponsor and Comerica Bank and Trust, N.A. serves as Trustee of the Trust. Boon Administrative Services, Inc. (“BAS”) serves as the third-party administrator.

General

The Plan was established as an employee health and welfare benefit plan for the exclusive benefit of eligible employees of the Plan Sponsor and its affiliates, as amended. The Plan benefits include medical and pharmacy benefits for full-time and part-time employees.

At each annual enrollment, provisions, such as participant contribution rates, coverage, deductibles, copays, and out-of-pocket maximums, may change. Coverage is continued for employees who are on approved short-term disability leave or leave under the Family and Medical Leave Act of 1993 (“FMLA”). Former employees and their dependents are eligible for continued coverage for the number of months specified under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), if they so elect.

In March 2020, the Plan Sponsor laid off a significant number of employees as a result of the 2019 novel coronavirus (or "COVID-19") pandemic. The Plan Sponsor, in its sole discretion, opted to continue coverage under the Plan through November 2020 for terminated full-time employees at certain work locations.

Eligibility

In general, all employees of the Plan Sponsor and its affiliates are eligible to participate in benefits offered by the Plan, as further described in the Plan documents, with respect to himself or herself on the first day of the month following completion of the service waiting period of 60 days. Qualified dependents and spouses are eligible, as further described in the Plan document.

Participating full-time employees that were terminated in March 2020 and subsequently rehired within 12 months were not subject to the service waiting period due to the Plan Sponsor’s discretionary continuation of coverage.

Contributions and Premiums

The Company pays contributions to the Plan to be used to fund benefits for employees based on either number of lives or hours worked. The employer contribution is a set dollar amount either per life or per hour worked by each employee, per month, pursuant to governmental requirements in force at each work location. Plan participants are responsible for payment of dependent cost of coverage, based on the level of coverage selected, through payroll deductions. These contributions are held in the Trust. BAS pays authorized benefits from the Trust as claims are processed by the Plan’s claims administrator.

The Plan Sponsor did not pay contributions to the Plan for those terminated full-time employees that received discretionary continuation of coverage. The contributions due for benefits were offset by the Plan's claims reserves.

Contributions are invested in assets held in a Trust bank account. The Trustee invests the Plan's funds as set forth in the Trust Agreement. Investments consist of money market funds and are reported at fair value.

Underwriters and actuaries of the insurance carriers have developed a set of rates applicable to the policies that have been issued to the Plan. The Plan Sponsor is quoted a premium rate based upon Plan design, location, and other demographic data. These rates are subject to change annually.

Benefits

The Plan benefits include self-insured medical and pharmacy benefits, Aetna Hospital Indemnity, Aetna Dental, and telemedicine benefits under the Smart Minimum Value Coverage Plan ("SmartMVP Plan") for full-time employees in San Francisco. The Plan provides self-insured medical benefits under the Smart Minimum Essential Coverage Plan ("SmartMEC Plan") for full-time employees in non-San Francisco cities. Contributions related to the self-funded medical plans and all other contributions are remitted to a lockbox maintained by BAS to be transferred into the Trust. Medical claims are processed by Boon-Chapman and pharmacy claims are processed by Caremark, but the responsibility for payments to the providers is retained by the Plan. The Employer maintains an excess risk policy that reimburses the Plan for medical and pharmacy claims in excess of certain limits. The Plan benefits also include fully-insured medical benefits under the Aetna Med Premier insurance plan for part-time employees. Contributions received related to Aetna premiums are paid directly from the Trust to BAS, which then remits the premium dollars to Aetna Life Insurance Company. Telemedicine benefits for participants enrolled in the SmartMVP Plan are provided at no additional cost to the Plan Sponsor. Instead, these benefits utilize the Plan's claims reserves and are based on the current number of enrolled employees, the historical claims utilization, and the available claims reserve amount. Should any of these factors fluctuate substantially, the Plan's claims reserves may not fund this benefit for the entire year.

Administrative Fees and Expenses

Administrative fees such as, but not limited to, administrative service fees, trustee fees, PPO access, medical management, audit and accounting fees, and investment management fees, are paid by the Plan, as allowed by the Plan document. The Company pays all other expenses.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the Plan are prepared on the modified cash basis of accounting, which is a comprehensive basis of accounting other than generally accepted accounting principles ("GAAP"). GAAP requires the accrual basis of accounting whereby revenues are recognized as earned and expenses are recognized as incurred. Under the modified cash basis of accounting, incurred but not recorded claims are disclosed in the notes to financial statements rather than accrued in the financial statements. See Note 5.

Use of Estimates

The preparation of financial statements in conformity with the modified cash basis of accounting, which is a comprehensive basis of accounting other than GAAP, requires the Plan administrator to make estimates and assumptions that affect the amounts reported in either the financial statements, accompanying notes, or supplemental schedules. Actual results could differ from those estimates.

Risks and Uncertainties
The Plan provides for investments in various investment securities which, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near-term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits - modified cash basis. The Plan's investments are managed and monitored by the Trustee in accordance with the Plan's investment policy.

COVID-19 has adversely affected and may continue to adversely affect economic activity globally, nationally and locally. Following the COVID-19 outbreak in March 2020, the values of investment securities have experienced significant volatility. These economic and market conditions and other effects of the COVID-19 outbreak may continue to cause volatility. The extent of the adverse impact of the COVID-19 outbreak on the Plan's account balances cannot be predicted at this time.

Investment Valuation and Income Recognition
The Plan's investments are recorded at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value of the money market fund is based on quoted prices in active markets. See Note 3 for discussion of fair value measurements. Purchases and sales of securities are recorded on a trade-date basis. Dividend income is recorded on the accrual basis.

Payment of Benefits
Health claims are recorded when paid. Any refunds due to overpayments, subrogation, or adjustments are recorded in the period received and are shown netted with benefit payments. Premiums are recorded when incurred.

Excess Risk Insurance
The Plan Sponsor limits potential claim liabilities through stop-loss insurance. The policy in effect during the year ended December 31, 2020, provided specific loss coverage for all claims under the SmartMVP Plan exceeding $50,000 in liability per person and when annual losses exceed an aggregate limit. The aggregate limit was $656,396 for the year ended December 31, 2020. The maximum specific benefit is unlimited for the policy period, whereas the maximum aggregate benefit is $1,000,000. The Plan remains liable to the extent the insurer cannot meet its obligations under the stop-loss insurance policy.

Administrative Expenses
The Plan is responsible for payment of the administrative expenses and fees; however, the Company may pay the Plan expenses directly.

Subsequent Events
The Plan's management has evaluated subsequent events through September 28, 2021, the date which the financial statements were available to be issued. Based upon this evaluation, the Plan has determined that no subsequent events have occurred which require adjustment to or disclosure in the financial statements.

3. FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The three levels of the fair value hierarchy under Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 820, *Fair Value Measurements and Disclosures*, are described below:

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

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2020 and 2019:

Money Market Fund: Valued at the daily closing price as reported by the fund. The money market fund held by the Plan is an open-end fund that is registered with the Securities and Exchange Commission. The fund is required to publish its daily net asset value ("NAV") and to transact at that price. The money market fund held by the Plan is deemed to be actively traded.

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

The following tables set forth by level, within the fair value hierarchy, the Plan's investment assets measured at fair value at December 31, 2020 and 2019:

	2020			
	Level 1	**Level 2**	**Level 3**	**Total**
Money market fund	$ 1,878,306	$ -	$ -	$ 1,878,306

	2019			
	Level 1	**Level 2**	**Level 3**	**Total**
Money market fund	$ 2,002,177	$ -	$ -	$ 2,002,177

4. INVESTMENTS AND INFORMATION PROVIDED AND CERTIFIED BY TRUSTEE (UNAUDITED)

The Plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the Trustee has certified the completeness and accuracy of all investments and related investment activity in the accompanying statements of net assets available for benefits - modified cash basis as of December 31, 2020 and 2019, and the statement of changes in net assets available for benefits - modified cash basis for the year ended December 31, 2020, and the accompanying supplemental schedule of assets (held at end of year) - modified cash basis and schedule of reportable transactions - modified cash basis as of and for the year ended December 31, 2020. No auditing procedures were performed by the independent public accountants as permitted by 29 CFR 2520.103-8 of the DOL's Rules and Regulations for Reporting and Disclosure under ERISA with respect to information certified as complete and accurate by the Trustee, except for comparing such information with the related information included in the financial statements and supplemental schedules.

5. CLAIMS INCURRED BUT NOT REPORTED

The Plan has not recorded an accrual for claims incurred, but not reported ("IBNR") at year-end. IBNR as of December 31, 2020 and 2019, for health claims incurred by active participants but not reported at that date, for accumulated eligibility of participants are estimated by the Company by analyzing claim lag studies. Such amounts are disclosed at an undiscounted amount because amounts typically are payable within one year. Any differences in the amounts estimated and actual amounts will be disclosed in future years. As of December 31, 2020 and 2019, the total estimated liability for claims incurred and not reported was $150 and $7,382, respectively, including amounts that may be covered by the insurance carrier under the aggregate excess risk benefit agreement.

6. PARTY-IN-INTEREST TRANSACTIONS

Plan assets include investment in funds managed by the Trustee. BAS is the third-party administrator. Transactions with the Trustee and third-party administrator qualify as exempt party-in-interest transactions under ERISA. Fees paid to the Trustee were $3,000 for the year ended December 31, 2020. The Boon Insurance Agency, Inc. ("BIA"), an affiliate of BAS, receives allowable commissions and BAS receives administrative fees paid out of premiums received by the Plan's insurance carrier for fully-insured Plan benefits. Payments to BAS related to services rendered for general Plan and Trust administration for self-insured Plan benefits for the year ended December 31, 2020, totaled $123,521. Payments to BIA for marketing services rendered, including insurance proposals, enrollment and implementation support, and issuance of pre-enrollment forms for the year ended December 31, 2020, totaled $32,139.

At December 31, 2020 and 2019, receivables due from BAS include $7,065 and $203,856, respectively, for contributions remitted to the lockbox not yet transferred to the Trust. At December 31, 2019, receivables due from BAS also include $6,525 for other account adjustments. At December 31, 2020 and 2019, Plan payables include $2,852 and $28,505, respectively, due to BAS for Plan expenses.

7. PLAN TERMINATION

Upon termination of the Plan, the Trustee would distribute all remaining net assets in a nondiscriminatory manner for the benefit of participants and eligible persons. Remaining net assets are deemed to be those monies remaining after payment of all reasonable and necessary obligations and expenses of the Plan.

8. INCOME TAX STATUS

The Trust funding the Plan has not received an exemption letter from the Internal Revenue Service (“IRS”) stating that the Trust is tax-exempt under Section 501(a) of the Internal Revenue Code ("IRC") as a Voluntary Employee Beneficiary Association; therefore, the Trust is a taxable trust. As an employee welfare benefit plan and related taxable trust, the Plan and Trust are required to operate in conformity with the IRC and ERISA. The Plan administrator believes the Plan and Trust are currently designed and being operated in compliance with the applicable requirements of the IRC and ERISA. The Plan’s financial statements do not include a provision for income taxes as the Plan Sponsor is responsible for payment of any tax liability that may be due with regard to the Trust.

Plan management is required to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2020 and 2019, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the financial statements. Furthermore, there are no tax related interest or penalties for the periods presented in these financial statements.



SUPPLEMENTARY INFORMATION

Stink, Inc. Health Plan
Schedule H, Line 4i - Schedule of Assets (Held at End of Year) - Modified Cash Basis
EIN # 94-3136988, Plan # 502
December 31, 2020

(a)	(b) Identity of Issuer, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value (Units)	(d) Cost	(e) Current Value
	Goldman, Sachs & Co.	Financial Square Government Fund; 1,878,306 units	$ 1,878,306	$ 1,878,306

See Independent Auditor's Report.

Stink, Inc. Health Plan
Schedule H, Line 4j - Schedule of Reportable Transactions - Modified Cash Basis
EIN # 94-3136988, Plan # 502
Year Ended December 31, 2020

(a) Identity of Party Involved	(b) Description of Asset (Include Interest Rate and Maturity in Case of a Loan)	Number of Transactions	(c) Purchase Price	(d) Selling Price	(e) Lease Rental	(f) Expense Incurred with Transaction	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or (Loss)
Single Transactions									
Goldman, Sachs & Co.	Financial Square Government Fund	2	$ 460,035	N/A	N/A	N/A	$ 460,035	$ 460,035	$ -
Goldman, Sachs & Co.	Financial Square Government Fund	2	N/A	$ 282,548	N/A	N/A	$ 282,548	$ 282,548	$ -
Series of Transactions – Same Security									
Goldman, Sachs & Co.	Financial Square Government Fund	25	$ 735,194	N/A	N/A	N/A	$ 735,194	$ 735,194	$ -
Goldman, Sachs & Co.	Financial Square Government Fund	64	N/A	$ 857,305	N/A	N/A	$ 857,305	$ 857,305	$ -

See Independent Auditor's Report.

Stink, Inc. Health Plan
Schedule H, Line 4j - Schedule of Reportable Transactions - Modified Cash Basis
EIN # 94-3136988, Plan # 502
Year Ended December 31, 2020

(a) Identity of Party Involved	(b) Description of Asset (Include Interest Rate and Maturity in Case of a Loan)	Number of Transactions	(c) Purchase Price	(d) Selling Price	(e) Lease Rental	(f) Expense Incurred with Transaction	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or (Loss)
Single Transactions									
Goldman, Sachs & Co.	Financial Square Government Fund	2	$ 460,035	N/A	N/A	N/A	$ 460,035	$ 460,035	$ -
Goldman, Sachs & Co.	Financial Square Government Fund	2	N/A	$ 282,548	N/A	N/A	$ 282,548	$ 282,548	$ -
Series of Transactions – Same Security									
Goldman, Sachs & Co.	Financial Square Government Fund	25	$ 735,194	N/A	N/A	N/A	$ 735,194	$ 735,194	$ -
Goldman, Sachs & Co.	Financial Square Government Fund	64	N/A	$ 857,305	N/A	N/A	$ 857,305	$ 857,305	$ -

See Independent Auditor's Report.

Stink, Inc. Health Plan
Schedule H, Line 4i - Schedule of Assets (Held at End of Year) - Modified Cash Basis
EIN # 94-3136988, Plan # 502
December 31, 2020

(a)	(b) Identity of Issuer, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value (Units)	(d) Cost	(e) Current Value
	Goldman, Sachs & Co.	Financial Square Government Fund; 1,878,306 units	$ 1,878,306	$ 1,878,306

See Independent Auditor's Report.

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

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

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

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

D Check box if filing under:
- ☒ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan
STINK, INC. HEALTH PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/2015

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)

STINK, INC.
420 COLUMBUS AVENUE
SAN FRANCISCO CA 94133

2b Employer Identification Number (EIN)
94-3136988

2c Plan Sponsor's telephone number
415-781-7673

2d Business code (see instructions)
722511

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	Dante Serafini	10/2/21	DANTE SERAFINI
	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

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

Form 5500 (2020)
v. 200204

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