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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/2007

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)
GULFSIDE HEALTHCARE SERVICES, INC.

2061 COLLIER PKWY
LAND O LAKES, FL 34639-5202

2b Employer Identification Number (EIN) 83-2484312

2c Plan Sponsor's telephone number 800-561-4883

2d Business code (see instructions) 621610

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.	10/08/2021	LINDA L. WARD
	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:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5 Total number of participants at the beginning of the plan year	**5**	317
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)**	286
a(2) Total number of active participants at the end of the plan year	**6a(2)**	341
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	51
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	392
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	1
f Total. Add lines **6d** and **6e**	**6f**	393
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	373
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	48
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:

2F 2G 2S 2T

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] 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)** [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

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)** [X] **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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

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

D Employer Identification Number (EIN)
83-2484312

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
MUTUAL OF AMERICA

(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
13-1614399	88668	061121I	393	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
0	1929

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

TAMPA BAY REGIONAL OFFICE
BAYPORT PLAZA 3000 BAYPORT DRIVE, S
UITE 1125
TAMPA, FL 33607-8402

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1929	PORTION OF INCENTIVE COMP. PROGRAM	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	

(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	232431
5	Current value of plan's interest under this contract in separate accounts at year end	5	2927468

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ N/A

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

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

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

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

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

b	Balance at the end of the previous year			7b	152533
c	Additions: (1) Contributions deposited during the year	7c(1)	50721		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	1850		
	(4) Transferred from separate account	7c(4)	51456		
	(5) Other (specify below)	7c(5)	13614		
	▶ ROLLOVER				
	(6) Total additions			7c(6)	117641
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	270174
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	37661		
	(2) Administration charge made by carrier	7e(2)	82		
	(3) Transferred to separate account	7e(3)	0		
	(4) Other (specify below)	7e(4)	0		
	▶				
	(5) Total deductions			7e(5)	37743
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	232431

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)**	0
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)**	0
(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)**	0
(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

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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

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

D Employer Identification Number (EIN)
83-2484312

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
VARIABLE ANNUITY 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
74-1625348	70238	68589	136	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
0	518

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

KYLE BLAIR
2929 ALLEN PARKWAY
ALLEN, TX 77019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
0	452	COMMISSIONS	3

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

CHRIS BROWN
2929 ALLEN PARKWAY
ALLEN, TX 77019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
0	28	COMMISSIONS	3

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

ERIC HOLMES

2929 ALLEN PARKWAY
HOUSTON, TX 77019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
0	21	COMMISSIONS	3

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

DAVID HILBIG

2929 ALLEN PARKWAY
HOUSTON, TX 77019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
0	17	COMMISSIONS	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	

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	316034
5	Current value of plan's interest under this contract in separate accounts at year end	5	1894848

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	368776
c	Additions: (1) Contributions deposited during the year	7c(1)	0		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	5867		
	(4) Transferred from separate account	7c(4)	45821		
	(5) Other (specify below)	7c(5)	0		
	▶				
	(6) Total additions			7c(6)	51688
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	420464
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	80322		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)	22789		
	(4) Other (specify below)	7e(4)	1319		
	▶ CONTRACT SURRENDER CHARGES				
	(5) Total deductions			7e(5)	104430
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	316034

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)**	0
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)**	0
(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)**	0
(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 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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

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

D Employer Identification Number (EIN)
83-2484312

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	
FIDELITY INVESTMENTS	82 DEVONSHIRE STREET BOSTON, MA 02109

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
VANGUARD	PO BOX 2600 VALLEY FORGE, PA 19482-2600

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
DWS	222 SOUTH RIVERSIDE PLAZA CHICAGO, IL 60606-5808

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
INVESCO OPPENHEIMER	PO BOX 5270 DENVER, CO 80217-5270

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

AMERICAN CENTURY INVESTMENTS

PO BOX 419786
KANSAS CITY, MO 64141-6786

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

CALVERT

4550 MONTGOMERY AVENUE SUITE 1000N
BETHESDA, MD 20814

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

AMERICAN FUNDS

333 SOUTH HOPE STREET
LOS ANGELES, CA 90071

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

PIMCO

840 NEWPORT CENTER DRIVE
NEWPORT BEACH, CA 92660

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

T. ROWE PRICE

100 EAST PRATT STREET
BALTIMORE, MD 21202

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

MFS

111 HUNTINGTON AVENUE
BOSTON, MA 02199

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

VICTORY FUNDS

4900 TIEDEMAN ROAD, 4TH FLOOR
BROOKLYN, OH 44144

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

NEUBERGER BERMAN

1290 AVENUE OF THE AMERICAS
NEW YORK, NY 10104

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

GOLDMAN SACHS VIT FUNDS

200 WEST STREET
NEW YORK, NY 10282

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

DELAWARE FUNDS

ONE COMMERCE SQUARE,
2005 MARKET STREET
PHILADELPHIA, PA 19103

(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)

MUTUAL OF AMERICA INVESTMENT CORP

320 PARK AVENUE
NEW YORK, NY 10022

(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 37 65	INSURANCE CARRIER	1641	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] 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 [ ]

(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 [ ]

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

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

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ 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 ☐

(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
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III	**Termination Information on Accountants and Enrolled Actuaries (see instructions)** (complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan 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.**

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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
GULFSIDE HEALTHCARE SERVICES, INC.

D Employer Identification Number (EIN)
83-2484312

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT NUMBER FS2

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
13-1614399-000	P	2927468

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN

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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

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

D Employer Identification Number (EIN)
83-2484312

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)	0	27276
(2) Participant contributions	1b(2)	0	0
(3) Other	1b(3)		
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)	49773	0
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	3638402	4744897
(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)	0	0
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	471536	636390
(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	4159711	5408563
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	4159711	5408563

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)	302746	
	(B) Participants	2a(1)(B)	673660	
	(C) Others (including rollovers)	2a(1)(C)	127326	
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		1103732
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)	0	
	(F) Other	2b(1)(F)	11050	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		11050
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
	(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)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		563625
(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		0
d Total income. Add all **income** amounts in column (b) and enter total	2d		1678407
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	420363	
(2) To insurance carriers for the provision of benefits	2e(2)	0	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		420363
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		0
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	9192	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		9192
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		429555
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		1248852
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: MSL, P.A. **(2)** EIN: 59-3070669

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		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**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 _____.

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

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
403(B) THRIFT PLAN OF GULFSIDE HEALTHCARE SERVICES, INC.

B Three-digit plan number (PN) ▶ 002

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

D Employer Identification Number (EIN)
83-2484312

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): 13-3590259

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** 0

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 contributed more than 5% of total contributions to the plan during the plan year (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) through (c)

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

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_____

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

FINANCIAL STATEMENTS AND
SUPPLEMENTAL SCHEDULE

Year Ended December 31, 2020

C O N T E N T S

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MSL
Certified Public Accountants

REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors and Plan Administrator
403(b) Thrift Plan for Gulfside Healthcare Services, Inc.
Land O' Lakes, Florida

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of 403(b) Thrift Plan for Gulfside Healthcare Services, Inc. (the "Plan"), which comprise the statements of net assets available for benefits as of December 31, 2020, and the related statement of changes in net assets available for benefits for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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 audit 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 unable 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 3 to the financial statements, which was certified by Mutual of America Life Insurance Company and Variable Annuity Life Insurance Company (the "Plan Custodians"), except for comparing such information with the related information included in the financial statements. We have been informed by the Plan administrator that the Plan Custodians hold the Plan's investment assets and execute investment transactions. The Plan administrator has obtained a certification from the Plan Custodians as of and for the year ended December 31, 2020, that the information provided to the Plan administrator by the Plan Custodians 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 been unable to obtain sufficient, appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Other Matter – Supplemental Schedule

The supplemental schedule of assets (held at end of year) as of December 31, 2020 is required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and is presented for the purpose of additional analysis and is 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 this supplemental schedule.

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

The form and content of the information included in the 2020 financial statements and supplemental schedule, other than that derived from the information certified by the Plan Custodians, has been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, is presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

Other Matter - 2019 Financial Statements

The financial statements of the Plan as of December 31, 2019, were audited by predecessor auditors. As permitted by 29 CFR 2520.103-8 of the DOL's Rules and Regulations for Reporting and Disclosure under ERISA, the Plan administrator instructed the predecessor auditors not to perform, and they did not perform, any auditing procedures with respect to the information certified by the Plan Custodians. Their report, dated July 28, 2020, indicated that (a) because of the significance of the information that they did not audit, they were unable to obtain sufficient, appropriate audit evidence to provide a basis for an audit opinion and, accordingly, they did not express an opinion on the financial statements and (b) the form and content of the information included in the financial statements, other than that derived from the information certified by the Plan Custodians, was presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

MSL, P.A.

Certified Public Accountants

Orlando, Florida
October 7, 2021

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

December 31, 2020 and 2019

	2020	2019
ASSETS		
Investments:		
Pooled separate accounts, at fair value	**$ 4,744,897**	$ 3,518,670
Insurance company general accounts, at contract value	**636,390**	641,041
TOTAL INVESTMENTS	**5,381,287**	4,159,711
Receivables:		
Employer contributions	**27,276**	-
TOTAL RECEIVABLES	**27,276**	-
TOTAL ASSETS	**5,408,563**	4,159,711
LIABILITIES	**-**	-
NET ASSETS AVAILABLE FOR BENEFITS	**$ 5,408,563**	$ 4,159,711

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

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

Year Ended December 31, 2020

INVESTMENT ACTIVITY:		
Net appreciation in fair value of investments		$ 563,625
Interest and dividends		11,050
	TOTAL INVESTMENT ACTIVITY	574,675
CONTRIBUTIONS:		
Participants		673,660
Employer		302,746
Rollovers		120,445
Other		6,881
	TOTAL CONTRIBUTIONS	1,103,732
DEDUCTIONS:		
Benefits paid to participants		420,363
Administrative expenses		9,192
	TOTAL DEDUCTIONS	429,555
	NET INCREASE IN NET ASSETS	1,248,852
NET ASSETS AVAILABLE FOR BENEFITS - BEGINNING OF YEAR		4,159,711
NET ASSETS AVAILABLE FOR BENEFITS - END OF YEAR		$ 5,408,563

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

403(b) THRIFT PLAN FOR GULFSIDE HEALTHCARE SERVICES, INC.

NOTES TO FINANCIAL STATEMENTS

Year Ended December 31, 2020

NOTE 1 - PLAN DESCRIPTION

The following description of 403(b) Thrift Plan for Gulfside Healthcare Services, Inc. (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Plan, which was established on January 1, 2007, and subsequently amended, is classified as a defined-contribution plan, covering all employees of Gulfside Healthcare Services, Inc. and Subsidiaries (the "Company"). The purpose of the Plan is to reward eligible employees of the Company for long and loyal service by providing them with retirement benefits. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Contributions

Immediately upon hire, substantially all employees of the Company may contribute a percentage of their pre-tax annual compensation, as defined in the Plan, up to the maximum allowed by the Internal Revenue Service ("IRS") on an annual basis. Employees who attain the age of 50 before the close of the calendar year are permitted to make additional Catch-Up Contributions, as prescribed by the Internal Revenue Code ("IRC"). Contribution deferral percentages can be changed throughout the year.

The Company may, at its discretion, elect to make qualified matching contributions to the Plan. Employees who have completed one year of service, as defined by the Plan, and are age 18 or older, are eligible to receive Company matching contributions. For the year ended December 31, 2020, the Company's matching contribution was 100% of participant deferrals up to 2%, through June 30, 2020, and up to 4% of the participant's compensation for the remaining half of the year. The Company may also make discretionary contributions to the Plan each year. There was no discretionary contribution made during 2020. The Plan also includes an Automatic Contribution Arrangement where 1% of eligible participant wages will automatically be deferred unless an affirmative election is made.

NOTE 1 - PLAN DESCRIPTION *(Continued)*

Participant Accounts

A separate account is maintained for each participant. Each participant's account is credited with the participant's contribution, the Company's contribution, an allocation of Plan earnings, and may be charged for Plan 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 contributions, plus actual earnings thereon. Vesting in the remainder of their account is based on years of continuous service as follows:

Years of Service	Percentage Vested
1	0%
2	25%
3	50%
4	75%
5	100%

A participant is fully vested upon reaching early retirement age, death, or permanent disability.

Forfeited Accounts

Forfeited balances of terminated participants' non-vested accounts are used to reduce future Company contributions. The unallocated forfeitures account, which consists of the unused balance of terminated participants' non-vested employer contributions, approximated $11,000 and $7,000 at December 31, 2020 and 2019, respectively. During the year ended December 31, 2020, approximately $1,600 of forfeited account balances were used to offset employer contributions to the Plan.

Investment Options

Participants may direct their account balance among any of the investment options offered by the Plan, including pooled separate accounts and fixed interest accounts. Participants may change their investment options at any time, with certain exceptions.

NOTE 1 - PLAN DESCRIPTION *(Continued)*

Participant Loans with Plan Custodians

The Plan provides for participants to obtain loans directly from Mutual of America Life Insurance Company ("Mutual of America") or Variable Annuity Life Insurance Company ("VALIC") (collectively, the "Plan Custodians"), as opposed to borrowing from their individual accounts; accordingly, such loans are not deemed to be Plan assets. Participants may borrow a minimum of $1,000 up to a maximum equal to the lesser of $50,000, or 50%, of their vested account balance. Loan terms may not exceed five years, unless made to purchase a primary residence. The loans are collateralized by the balance in the participant's account and bear interest at a rate based on Moody's Average Corporate Yield for VALIC loans and for Mutual of America loans at a rate 3% higher than the crediting rate for amounts in their general account. Loans must be repaid to the Plan Custodians by the participant in accordance with the repayment terms of the agreement. In the event of default, foreclosure on the participant's account balance will not occur until a distributable event occurs in the Plan. At December 31, 2020 and 2019, the amount collateralized for participant loans held by the Plan Custodians approximated $134,000 and $170,000, respectively.

Payment of Benefits

Upon termination of service due to death, disability, or retirement, a participant may elect to receive either a lump-sum payment equal to the value of the participant's vested interest in their account, or installments or annuity payments over a fixed period of time, not to exceed the life expectancy of the participant/designated beneficiary. The Plan allows for in-service distributions if a participant reaches age 59 1/2 and hardship distributions subject to Plan provisions. If a participant terminates employment and the participant's account balance does not exceed $1,000, the Plan administrator may authorize the benefit payment without the participant's consent.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the Plan are presented on the accrual basis of accounting.

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 and disclosures in the financial statements. Actual results could differ from those estimates.

Investment Valuation and Income Recognition

Investments in pooled separate accounts are reported at fair value and are valued using a market valuation basis at the reported closing net asset value ("NAV") of the funds on the last business day of the Plan year. NAV is based on the fair market value of the funds' underlying investments, less any unpaid expenses.

Purchases and sales of securities are recorded on a trade-date basis, and interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. The net appreciation/depreciation in the fair value of the Plan's investments include the Plan's gains and losses on investments bought and sold, as well as the unrealized gains and losses on those investments that are held at the end of the year.

Investment contracts held by a defined-contribution plan are required to be reported at fair value, except for that portion of the net assets available for benefits of a defined-contribution plan attributable to fully benefit-responsive investment contracts. Contract value is deemed to be the relevant measurement attribute for those contracts, because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the Plan. Contract value represents contributions and reinvested income, less any withdrawals, plus accrued interest. The Plan's investments in the VALIC Fixed Account Plus, the VALIC Short Term Fixed Account, and the Mutual of America Interest Accumulation Account are stated at contract value (see Note 5).

Investment Risk

The Plan's investments are not insured and are subject to credit and market risks. Financial information relating to those investments is included in these financial statements, based on information provided by the Plan Custodians. 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, changes in the values of investment securities will occur in the near term and it is reasonably possible that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits.

Payment of Benefits

Benefits to participants are recorded when paid. As of December 31, 2020 and 2019, there were no amounts allocated to the accounts of individuals who have elected to withdraw from the Plan but had not yet been paid.

Administration and Investment Expenses

Certain administrative expenses and professional fees are paid directly by the Company and will not be reimbursed by the Plan. Investment-related fees and commissions are recorded in net appreciation/depreciation in fair value of investments.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *(Continued)*

Reclassifications

Certain amounts in the financial statements for the year ended December 31, 2019 have been reclassified to conform to the 2020 presentation. Such reclassifications had no effect on the previously reported change in net assets.

Subsequent Events

In preparing these financial statements, the Company has evaluated events and transactions for potential recognition or disclosure through October 7, 2021, the date the financial statements were available to be issued.

NOTE 3 - INFORMATION CERTIFIED BY THE PLAN CUSTODIANS

The Plan Custodians hold the Plan's investments and execute all investment transactions. All investment information disclosed in the financial statements and supplemental schedule, including investments held at December 31, 2020 and 2019, net appreciation in fair value of investments, and dividends and interest for the year ended December 31, 2020, was obtained or derived from information supplied to the Plan administrator and certified as complete and accurate by the Plan Custodians.

NOTE 4 - FAIR VALUE MEASUREMENT

The fair value of financial instruments is presented based upon a hierarchy of levels 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 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. The three levels of the fair value hierarchy are described as follows:

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 that are observable, either directly or indirectly, 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. 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.

NOTE 4 - FAIR VALUE MEASUREMENT *(Continued)*

The following tables set forth by level, within the fair value hierarchy, the Plan's investments recorded at fair value as of December 31, 2020 and 2019:

	December 31, 2020			
	Level 1	**Level 2**	**Level 3**	**Total**
Pooled Separate Accounts	**$ -**	**$ 4,744,897**	**$ -**	**$ 4,744,897**

	December 31, 2019			
	Level 1	Level 2	Level 3	Total
Pooled Separate Accounts	$ -	$ 3,518,670	$ -	$ 3,518,670

NOTE 5 - FULLY BENEFIT-RESPONSIVE INVESTMENT CONTRACTS

Investments held in unallocated insurance company contracts are invested in the VALIC Fixed Account Plus, the VALIC Short Term Fixed Account, and the Mutual of America Interest Accumulation Account. These funds are deemed to be fully benefit-responsive investment contracts and are reported at contract value. Contract value is the relevant measure for fully benefit-responsive investment contracts because this is the amount received by participants if they were to initiate permitted transactions under the terms of the Plan. Contract value represents contributions made under each 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. However, withdrawals influenced by Company-initiated events, such as reallocation of investments, may result in a distribution at other than contract value, and are subject to certain restrictions. The Plan's ability to receive amounts due in accordance with fully benefit-responsive contracts is dependent on the contract issuer's ability to meet its financial obligations. There are no reserves against contract values for credit risk of the contract issuer or otherwise.

The VALIC Fixed Account Plus, the VALIC Short Term Fixed Account, and the Mutual of America Interest Accumulation Account contracts held by the Plan are guaranteed investment contracts. The contract issuer is contractually obligated to repay the principal and interest at a specified interest rate that is guaranteed to the Plan. For the year ended December 31, 2020, the average yield for the VALIC fixed accounts and the Mutual of America Interest Accumulation Account approximated 2.0% and 1.0%, respectively.

NOTE 6 - INCOME TAX STATUS

The Plan is intended to be qualified under Section 403(b) of the IRC and is subject to the provisions of ERISA. The Plan document is a prototype plan prepared and maintained by Mutual of America. The prototype plan received a determination of qualification from the IRS. The Plan administrator believes that the Plan, as amended, is currently designed and being operated in compliance with the applicable requirements of the IRC and will remain exempt from federal income taxes.

NOTE 7 - PARTY-IN-INTEREST TRANSACTIONS

During 2020, certain Plan investments were managed by the Plan Custodians and, therefore, these transactions qualify as party-in-interest transactions.

NOTE 8 - PLAN TERMINATION

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

NOTE 9 - COVID-19 PANDEMIC

In late 2019, a novel strain of COVID-19, also known as coronavirus, was identified as the cause of a disease outbreak which was declared a pandemic by the World Health Organization in March 2020. The effect of COVID-19 on the Plan's operational and financial performance and its impact on capital and financial markets on a global scale will depend on future developments associated with this pandemic that are uncertain and difficult to predict. These financial statements do not include any adjustments related to the ultimate outcome of these uncertainties.

NOTE 10 - CARES ACT

On March 27, 2020, congress signed into law Section 2202 of the Coronavirus Aid, Relief, and Economic Security ("CARES") Act which provided plan sponsors the option of adopting, among other things, temporary provisions that would ease certain restrictions on taking of plan distributions.

As of March 30, 2020, the Plan operationally adopted modified distribution options in which qualified participants may withdraw up to $100,000 from their vested balance. These distributions are not subject to the 10% early distribution penalty and the income tax associated with the distribution may be paid ratably over a three-year period.

These provisions are extended to any Plan participants regardless of age and employment status as long as they have been diagnosed with COVID-19 or have a spouse or dependent diagnosed with COVID-19, or have experienced adverse financial consequences as a result of being quarantined, furloughed, laid off, having to work reduced hours due to the virus, or being unable to work due to lack of childcare due to the virus or business closure. These special distribution provisions expired on December 31, 2020.

The Plan has until December 31, 2022, to formally amend the Plan and adopt these provisions of the CARES Act.

SUPPLEMENTAL SCHEDULE

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

FORM 5500 - SCHEDULE H, LINE 4(i) -
SCHEDULE OF ASSETS (HELD AT END OF YEAR)
EIN: 83-2484312
Plan Number: 002

December 31, 2020

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment	(e) Current Value
	Pooled Separate Accounts:		
*	The Variable Annuity Life Insurance Company	Aggressive Growth Lifestyle	$ 41,868
*	The Variable Annuity Life Insurance Company	Blue Chip Growth Fund	64,811
*	The Variable Annuity Life Insurance Company	Capital Conservation	406
*	The Variable Annuity Life Insurance Company	Conservative Growth Lifestyle	95,844
*	The Variable Annuity Life Insurance Company	Core Bond Fund	52,218
*	The Variable Annuity Life Insurance Company	Dividend Value	46,516
*	The Variable Annuity Life Insurance Company	Emerging Economies	107,014
*	The Variable Annuity Life Insurance Company	Global Real Estate Fund	36,072
*	The Variable Annuity Life Insurance Company	Government Money Market I Fund	25,822
*	The Variable Annuity Life Insurance Company	Government Money Market II Fund	392
*	The Variable Annuity Life Insurance Company	Health Sciences Fund	40,217
*	The Variable Annuity Life Insurance Company	High Yield Bond Fund	34,221
*	The Variable Annuity Life Insurance Company	Inflation Protected Fund	40,249
*	The Variable Annuity Life Insurance Company	International Value Fund	78,932
*	The Variable Annuity Life Insurance Company	International Equities Index Fund	142,366
*	The Variable Annuity Life Insurance Company	International Opportunities	85,671
*	The Variable Annuity Life Insurance Company	Large Cap Core	140
*	The Variable Annuity Life Insurance Company	Large Cap Value Fund	3,086
*	The Variable Annuity Life Insurance Company	Mid Cap Growth Fund	7,623
*	The Variable Annuity Life Insurance Company	Mid Cap Index Fund	152,008
*	The Variable Annuity Life Insurance Company	Mid Cap Value Fund	92,353
*	The Variable Annuity Life Insurance Company	Moderate Growth Lifestyle	76,848
*	The Variable Annuity Life Insurance Company	NASDAQ-100(R) Index Fund	16,016
*	The Variable Annuity Life Insurance Company	Science & Technology Fund	2,041
*	The Variable Annuity Life Insurance Company	Small Cap Aggressive Growth	45,810
*	The Variable Annuity Life Insurance Company	Small Cap Index Fund	37,162
*	The Variable Annuity Life Insurance Company	Small Cap Value Fund	40,023
*	The Variable Annuity Life Insurance Company	Stock Index Fund	126,088
*	The Variable Annuity Life Insurance Company	Strategic Bond Fund	462
*	The Variable Annuity Life Insurance Company	U.S. Socially Responsible Fund	114,080
	T. Rowe Price	Retirement 2020 Advisor Fund	41,939
	T. Rowe Price	Retirement 2025 Advisor Fund	33,838
	T. Rowe Price	Retirement 2030 Advisor Fund	914
	T. Rowe Price	Retirement 2035 Advisor Fund	8,769
	T. Rowe Price	Retirement 2040 Advisor Fund	2,789
	Vanguard	Lifestrategy Conservative Growth Fund	349
	Vanguard	Lifestrategy Growth Fund	1,291
	Vanguard	Lifestrategy Moderate Growth Fund	32,074
	Vanguard	Windsor II Fund	89,107

See Report of Independent Certified Public Accountants.

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

FORM 5500 - SCHEDULE H, LINE 4(i) -
SCHEDULE OF ASSETS (HELD AT END OF YEAR) *(Continued)*
EIN: 83-2484312
Plan Number: 002

December 31, 2020

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment	(e) Current Value
	Pooled Separate Accounts *(Continued)* :		
	American Century	VP Capital Appreciation	$ 29,742
	American Funds	Insurance Series New World Fund	5,653
	Calvert	VP SRI Balanced Portfolio	2,728
	Delaware Funds	VIP Small Cap Value Series	90
	DWS	Capital Growth VIP	18,048
	Fidelity Investments	VIP Asset Manager Portfolio	5
	Fidelity Investments	VIP Contrafund Portfolio	14,128
	Fidelity Investments	VIP Equity - Income Portfolio	2,701
	Fidelity Investments	VIP Mid Cap Portfolio	1,688
	Goldman Sachs	VIT Small Cap Equity Insights Fund	485
	Goldman Sachs	VIT US Equity Insights Fund	121
	Invesco Oppenheimer	V.I. Main Street VA	171
	MFS	VIT III Mid Cape Value Portfolio	94
*	Mutual of America Life Insurance Company	2015 Retirement Fund	401
*	Mutual of America Life Insurance Company	2020 Retirement Fund	97,073
*	Mutual of America Life Insurance Company	2025 Retirement Fund	304,051
*	Mutual of America Life Insurance Company	2030 Retirement Fund	525,737
*	Mutual of America Life Insurance Company	2035 Retirement Fund	525,231
*	Mutual of America Life Insurance Company	2040 Retirement Fund	266,180
*	Mutual of America Life Insurance Company	2045 Retirement Fund	351,082
*	Mutual of America Life Insurance Company	2050 Retirement Fund	158,987
*	Mutual of America Life Insurance Company	2055 Retirement Fund	193,530
*	Mutual of America Life Insurance Company	2060 Retirement Fund	21,925
*	Mutual of America Life Insurance Company	2065 Retirement Fund	91
*	Mutual of America Life Insurance Company	Aggressive Allocation Fund	69,584
*	Mutual of America Life Insurance Company	All America Fund	1,094
*	Mutual of America Life Insurance Company	Bond Fund	8,478
*	Mutual of America Life Insurance Company	Composite Fund	5
*	Mutual of America Life Insurance Company	Conservative Allocation Fund	20,554
*	Mutual of America Life Insurance Company	Equity Index Fund	71,873
*	Mutual of America Life Insurance Company	International Fund	8,124
*	Mutual of America Life Insurance Company	Mid-Cap Value Fund	78
*	Mutual of America Life Insurance Company	Mid-Cap Equity Index Fund	21,735
*	Mutual of America Life Insurance Company	Mid-Term Bond Fund	4,145
*	Mutual of America Life Insurance Company	Moderate Allocation Fund	82,767
*	Mutual of America Life Insurance Company	Money Market Fund	4,705

See Report of Independent Certified Public Accountants.

403(b) THRIFT PLAN FOR
GULFSIDE HEALTHCARE SERVICES, INC.

FORM 5500 - SCHEDULE H, LINE 4(i) -
SCHEDULE OF ASSETS (HELD AT END OF YEAR) *(Continued)*
EIN: 83-2484312
Plan Number: 002

December 31, 2020

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment	(e) Current Value
	Pooled Separate Accounts *(Continued)* :		
*	Mutual of America Life Insurance Company	Retirement Income Fund	$ 9,217
*	Mutual of America Life Insurance Company	Small Cap Equity Income Fund	1,091
*	Mutual of America Life Insurance Company	Small Cap Growth Fund	17,129
*	Mutual of America Life Insurance Company	Small Cap Value Fund	4,095
	Neuberger Berman	AMT Sustainable Equity Portfolio	146
	PIMCO	VIT Real Return Portfolio	5
	T. Rowe Price	Blue Chip Growth Portfolio	27,436
	Vanguard	VIF Diversified Value Portfolio	24,857
	Vanguard	VIF International Portfolio	12,148
	Vanguard	VIF REIT Index Portfolio	12,781
	Vanguard	VIF Total Bond Market Index Portfolio	5,421
	Victory RS	Small Cap Growth Equity VIP Series	58
			$ 4,744,897
	Insurance Company General Accounts:		
*	The Variable Annuity Life Insurance Company	Fixed Account Plus (contract value)	$ 399,737
*	The Variable Annuity Life Insurance Company	Short Term Fixed Account (contract value)	4,222
*	Mutual of America Life Insurance Company	Interest Accumulation Account (contract value)	232,431
			$ 636,390

* *Party-in-interest*

See Report of Independent Certified Public Accountants.

Attachment to January 2020 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name	403(B) THRIFT PLAN OF	EIN:	83-2484312
Plan Sponsor's Name	GULFSIDE HEALTHCARE SERVICES, IN	PN:	002

(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.	(d) Cost	(e)Current Value
*	The Variable Annuity Life Insurance Company	Aggressive Growth Lifestyle		$41,868.00
*	The Variable Annuity Life Insurance Company	Blue Chip Growth Fund		$64,811.00
*	The Variable Annuity Life Insurance Company	Capital Conservation		$406.00
*	The Variable Annuity Life Insurance Company	Conservative Growth Lifestyle		$95,844.00
*	The Variable Annuity Life Insurance Company	Core Bond Fund		$52,218.00
*	The Variable Annuity Life Insurance Company	Dividend Value		$46,516.00
*	The Variable Annuity Life Insurance Company	Emerging Economies		$107,014.00
*	The Variable Annuity Life Insurance Company	Global Real Estate Fund		$36,072.00
*	The Variable Annuity Life Insurance Company	Government Money Market I Fund		$25,822.00
*	The Variable Annuity Life Insurance Company	Government Money Market II Fund		$392.00
*	The Variable Annuity Life Insurance Company	Health Sciences Fund		$40,217.00
*	The Variable Annuity Life Insurance Company	High Yield Bond Fund		$34,221.00
*	The Variable Annuity Life Insurance Company	Inflation Protected Fund		$40,249.00
*	The Variable Annuity Life Insurance Company	International Value Fund		$78,932.00
*	The Variable Annuity Life Insurance Company	International Equities Index Fund		$142,366.00
*	The Variable Annuity Life Insurance Company	International Opportunities		$85,671.00
*	The Variable Annuity Life Insurance Company	Large Cap Core		$140.00
*	The Variable Annuity Life Insurance Company	Large Cap Value Fund		$3,086.00
*	The Variable Annuity Life Insurance Company	Mid Cap Growth Fund		$7,623.00
*	The Variable Annuity Life Insurance Company	Mid Cap Index Fund		$152,008.00
*	The Variable Annuity Life Insurance Company	Mid Cap Value Fund		$92,353.00
*	The Variable Annuity Life Insurance Company	Moderate Growth Lifestyle		$76,848.00
*	The Variable Annuity Life Insurance Company	NASDAQ-100(R) Index Fund		$16,016.00

Attachment to January 2020 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name	403(B) THRIFT PLAN OF	EIN:	83-2484312
Plan Sponsor's Name	GULFSIDE HEALTHCARE SERVICES, IN	PN:	002

(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.	(d) Cost	(e)Current Value
*	The Variable Annuity Life Insurance Company	Science & Technology Fund		$2,041.00
*	The Variable Annuity Life Insurance Company	Small Cap Aggressive Growth		$45,810.00
*	The Variable Annuity Life Insurance Company	Small Cap Index Fund		$37,162.00
*	The Variable Annuity Life Insurance Company	Small Cap Value Fund		$40,023.00
*	The Variable Annuity Life Insurance Company	Stock Index Fund		$126,088.00
*	The Variable Annuity Life Insurance Company	Strategic Bond Fund		$462.00
*	The Variable Annuity Life Insurance Company	U.S. Socially Responsible Fund		$114,080.00
	T Rowe Price	Retirement 2020 Advisor Fund		$41,939.00
	T Rowe Price	Retirement 2025 Advisor Fund		$33,838.00
	T Rowe Price	Retirement 2030 Advisor Fund		$914.00
	T Rowe Price	Retirement 2035 Advisor Fund		$8,769.00
	T Rowe Price	Retirement 2040 Advisor Fund		$2,789.00
	Vanguard	Lifestrategy Conservative Growth Fund		$349.00
	Vanguard	Lifestrategy Growth Fund		$1,291.00
	Vanguard	Lifestrategy Moderate Growth Fund		$32,074.00
	Vanguard	Windsor II Fund		$89,107.00
*	The Variable Annuity Life Insurance Company	Fixed Account Plus (contract value)		$399,737.00
*	The Variable Annuity Life Insurance Company	Short Term Fixed Account (contract value)		$4,222.00

Attachment to January 2020 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name	403(B) THRIFT PLAN OF	EIN:	83-2484312
Plan Sponsor's Name	GULFSIDE HEALTHCARE SERVICES, INC.	PN:	002

(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.	(d) Cost	(e)Current Value
	American Century	Investments® VP Capital Appreciation Fund		$ 29,742
	American Funds	Insurance Series® New World Fund®		$ 5,653
	Calvert	VP SRI Balanced Portfolio		$ 2,728
	Delaware	VIP® Small Cap Value Series		$ 90
	DWS	Capital Growth VIP		$ 18,048
	Fidelity®	VIP Asset Manager Portfolio		$ 5
	Fidelity®	VIP Contrafund® Portfolio		$ 14,128
	Fidelity®	VIP Equity-Income Portfolio		$ 2,701
	Fidelity®	VIP Mid Cap Portfolio		$ 1,688
	Goldman Sachs	VIT Small Cap Equity Insights Fund		$ 485
	Goldman Sachs	VIT US Equity Insights Fund		$ 121
	Invesco Oppenheimer	V.I. Main Street Fund®		$ 171
	MFS®	VIT III Mid Cap Value Portfolio		$ 94
*	Mutual of America	2015 Retirement Fund		$ 401
*	Mutual of America	2020 Retirement Fund		$ 97,073
*	Mutual of America	2025 Retirement Fund		$ 304,051
*	Mutual of America	2030 Retirement Fund		$ 525,737
*	Mutual of America	2035 Retirement Fund		$ 525,231
*	Mutual of America	2040 Retirement Fund		$ 266,180
*	Mutual of America	2045 Retirement Fund		$ 351,082
*	Mutual of America	2050 Retirement Fund		$ 158,987
*	Mutual of America	2055 Retirement Fund		$ 193,530
*	Mutual of America	2060 Retirement Fund		$ 21,925
*	Mutual of America	2065 Retirement Fund		$ 91
*	Mutual of America	Aggressive Allocation Fund		$ 69,584
*	Mutual of America	All America Fund		$ 1,094
*	Mutual of America	Bond Fund		$ 8,478

Attachment to January 2020 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name	403(B) THRIFT PLAN OF	EIN:	83-2484312
Plan Sponsor's Name	GULFSIDE HEALTHCARE SERVICES, INC.	PN:	002

(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.	(d) Cost	(e)Current Value
*	Mutual of America	Composite Fund		$ 5
*	Mutual of America	Conservative Allocation Fund		$ 20,554
*	Mutual of America	Equity Index Fund		$ 71,873
*	Mutual of America	International Fund		$ 8,124
*	Mutual of America	Mid Cap Value Fund		$ 78
*	Mutual of America	Mid-Cap Equity Index Fund		$ 21,735
*	Mutual of America	Mid-Term Bond Fund		$ 4,145
*	Mutual of America	Moderate Allocation Fund		$ 82,767
*	Mutual of America	Money Market Fund		$ 4,706
*	Mutual of America	Retirement Income Fund		$ 9,217
*	Mutual of America	Small Cap Equity Index Fund		$ 1,092
*	Mutual of America	Small Cap Growth Fund		$ 17,129
*	Mutual of America	Small Cap Value Fund		$ 4,095
	Neuberger Berman	AMT Sustainable Equity Portfolio		$ 146
	PIMCO	VIT Real Return Portfolio		$ 5
	T. Rowe Price	Blue Chip Growth Portfolio		$ 27,436
	Vanguard	VIF Diversified Value Portfolio		$ 24,857
	Vanguard	VIF International Portfolio		$ 12,148
	Vanguard	VIF Real Estate Index Portfolio		$ 12,781
	Vanguard	VIF Total Bond Market Index Portfolio		$ 5,421
	Victory RS	Small Cap Growth Equity VIP Series		$ 58
*	Mutual of America	General Account-outstanding balance participant loan balance		$ 56,543
*	Mutual of America	General Account-Group Annuity contract		$ 175,888