

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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 1.2em; font-weight: bold;">2020</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>04/01/1965</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>04/01/1965</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>04/01/1965</u>					
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>GAYLORD HOSPITAL, INC.</u> <u>50 GAYLORD FARMS ROAD</u> <u>WALLINGFORD, CT 06492</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>06-0646649</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>203-284-2848</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>06-0646649</u>	2c Plan Sponsor's telephone number <u>203-284-2848</u>	2d Business code (see instructions) <u>622000</u>	
2b Employer Identification Number (EIN) <u>06-0646649</u>					
2c Plan Sponsor's telephone number <u>203-284-2848</u>					
2d Business code (see instructions) <u>622000</u>					

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.	10/15/2021	WALTER G. HARPER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2020)
v. 200204

3a Plan administrator's name and address ☒ 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	388
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)	107
a(2) Total number of active participants at the end of the plan year		6a(2)	99
b Retired or separated participants receiving benefits.....		6b	132
c Other retired or separated participants entitled to future benefits		6c	141
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	372
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	8
f Total. Add lines 6d and 6e		6f	380
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		6h	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....		7	
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 1A 1I			
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) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor		9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)			
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☒ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☐ A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)	

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

<div>SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Single-Employer Defined Benefit Plan Actuarial Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).</div> <div>▶ File as an attachment to Form 5500 or 5500-SF.</div>	<div>OMB No. 1210-0110</div> <div>2020</div> <div>This Form is Open to Public Inspection</div>
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For calendar plan year 2020 or fiscal plan year beginning	01/01/2020	and ending	12/31/2020
▶ Round off amounts to nearest dollar.			
▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.			

A Name of plan EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.		B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF GAYLORD HOSPITAL, INC.		D Employer Identification Number (EIN) 06-0646649	
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B		F Prior year plan size: ☐ 100 or fewer ☒ 101-500 ☐ More than 500	

Part I Basic Information			
1 Enter the valuation date: Month 01 Day 01 Year 2020			
2 Assets:			
a Market value		2a	26108669
b Actuarial value		2b	24445756
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment.....	136	15127672	15127672
b For terminated vested participants.....	145	7268648	7268648
c For active participants	107	6930310	6948330
d Total.....	388	29326630	29344650
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... ☐			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....		4b	
5 Effective interest rate	5	5.68 %	
6 Target normal cost.....	6	360000	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<div>SIGN HERE</div>	<div>Signature of actuary</div> <div>NICOLE DEVOE, A.S.A., E.A.</div> <div>Type or print name of actuary</div> <div>TRANSAMERICA</div> <div>Firm name</div> <div>PO BOX 428 CEDAR RAPIDS, IA 52406-0428</div> <div>Address of the firm</div>	<div>09/23/2021</div> <div>Date</div> <div>20-06880</div> <div>Most recent enrollment number</div> <div>508-903-6014</div> <div>Telephone number (including area code)</div>
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Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>25.01</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		0
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.48</u> %		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		0
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	83.30 %
15 Adjusted funding target attainment percentage	15	80.34 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	76.83 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/14/2020	392054				
07/10/2020	267658				
10/13/2020	267658				
Totals ▶			18(b)	927370	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	902349

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost**21** Discount rate:**a** Segment rates:1st segment:
4.75 %2nd segment:
5.50 %3rd segment:
6.27 %☐ N/A, full yield curve used**b** Applicable month (enter code)**21b**

4

22 Weighted average retirement age**22**

64

23 Mortality table(s) (see instructions) ☐ Prescribed - combined☒ Prescribed - separate☐ Substitute**Part VI Miscellaneous Items****24** Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**25** Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**26** Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ☒ Yes ☐ No**27** If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.**27****Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years****28** Unpaid minimum required contributions for all prior years **28** 0**29** Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0**30** Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0**Part VIII Minimum Required Contribution For Current Year****31** Target normal cost and excess assets (see instructions):**a** Target normal cost (line 6) **31a** 360000**b** Excess assets, if applicable, but not greater than line 31a **31b** 0**32** Amortization installments:**a** Net shortfall amortization installment Outstanding Balance 4898894 Installment 459941**b** Waiver amortization installment 0 0**33** If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33****34** Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) **34** 819941

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0

36 Additional cash requirement (line 34 minus line 35) **36** 819941**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 902349**38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36) **38a** 82408**b** Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b** 0**39** Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0**40** Unpaid minimum required contributions for all years **40** 0**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)****41** If an election was made to use PRA 2010 funding relief for this plan:**a** Schedule elected ☐ 2 plus 7 years ☒ 15 years**b** Eligible plan year(s) for which the election in line 41a was made ☐ 2008 ☐ 2009 ☒ 2010 ☒ 2011

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	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 EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 GAYLORD HOSPITAL, INC.	D Employer Identification Number (EIN) 06-0646649	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. ☒ Yes ☐ No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
TRANSAMERICA RETIREMENT SOLUTIONS
13-3689044

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

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

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

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 12 15 28 38 50 59 61 62 63 64	RECORD KEEPER	113071	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

NORTHWESTERN MUTUAL INV. SERVICES

720 E WISCONSIN AVE
MILWAUKEE, WI 53202

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 53	BROKER	0	Yes ☒ No ☐	Yes ☐ No ☒	25000	Yes ☐ No ☒

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

NATIONAL FINANCIAL SERVICES

04-3523567

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
33 71	SECURITIES BROKER	0	Yes ☒ No ☐	Yes ☐ No ☒	0	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
NORTHWESTERN MUTUAL INV SERVICES	16 53	25000
(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.	
TRANSAMERICA RETIREMENT SOLUTIONS 13-3689044	COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NATIONAL FINANCIAL SERVICES	33 71	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
ARTISAN FUNDS 875 EAST WISCONSIN AVE SUITE 800 MILWAUKEE, WI 53202	REVENUE SHARING SEE ATTACHMENT TO LINE 2(H)	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NATIONAL FINANCIAL SERVICES	33 71	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
INVESCO 11 GREENWAY PLAZA SUITE 100 HOUSTON, TX 77046	REVENUE SHARING SEE ATTACHMENT TO LINE 2(H)	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NATIONAL FINANCIAL SERVICES	33 71	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
MFS 111 HUNTINGTON AVE BOSTON, MA 02199	REVENUE SHARING SEE ATTACHMENT TO LINE 2(H)	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(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
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(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

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

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2020 This Form is Open to Public Inspection
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>		
A Name of plan <u>EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>GAYLORD HOSPITAL, INC.</u>	D Employer Identification Number (EIN) <u>06-0646649</u>	

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)	8277660
(2) Participant contributions.....		1b(2)	
(3) Other		1b(3)	
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)		1c(1)	
(2) U.S. Government securities		1c(2)	
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred		1c(3)(A)	
(B) All other.....		1c(3)(B)	
(4) Corporate stocks (other than employer securities):			
(A) Preferred		1c(4)(A)	
(B) Common		1c(4)(B)	
(5) Partnership/joint venture interests		1c(5)	
(6) Real estate (other than employer real property)		1c(6)	
(7) Loans (other than to participants).....		1c(7)	
(8) Participant loans		1c(8)	
(9) Value of interest in common/collective trusts		1c(9)	
(10) Value of interest in pooled separate accounts		1c(10)	
(11) Value of interest in master trust investment accounts		1c(11)	
(12) Value of interest in 103-12 investment entities		1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds)		1c(13)	2530165629408788
(14) Value of funds held in insurance company general account (unallocated contracts).....		1c(14)	
(15) Other.....		1c(15)	

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(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	26129422	29408788

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 through 1j)	1k		

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	26129422	29408788
---	-----------	----------	----------

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)	927370	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		927370
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends: (A) Preferred stock.....	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	1305339	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1305339
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		3601914
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		5834623

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	2192314	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		2192314
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)	57333	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other.....	2i(4)	305610	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		362943
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		2555257

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		3279366
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) ☒ Disclaimer (4) ☐ Adverse

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

(1) ☒ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☐ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: CROWE, LLP

(2) EIN: 35-0921680

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:

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.)

	Yes	No	Amount
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?	X		10000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
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.)	X		
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.)	X		
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?		X	
4k		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
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 <u>4333120</u> .			

<div>SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Retirement Plan Information</div> <div>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).</div> <div>▶ File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2020</div> <div>This Form is Open to Public Inspection.</div>
For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020		
A Name of plan EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 GAYLORD HOSPITAL, INC.		D Employer Identification Number (EIN) 06-0646649
Part I	Distributions	
All references to distributions relate only to payments of benefits during the plan year.		
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....		1 0
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 13-3689044		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year		3 5
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		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule R (Form 5500) 2020 v. 200204		

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 _____

**EMPLOYEES' RETIREMENT PLAN
OF GAYLORD HOSPITAL, INC.**

FINANCIAL STATEMENTS
December 31, 2020 and 2019

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.

FINANCIAL STATEMENTS
December 31, 2020 and 2019

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INDEPENDENT AUDITOR'S REPORT

To the Plan Administrator of
Employees' Retirement Plan of Gaylord Hospital, Inc.
Wallingford, Connecticut

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Employees' Retirement Plan of Gaylord Hospital, Inc. (the Plan), which comprise the statements of net assets available for benefits as of December 31, 2020 and 2019, and the related statements of changes in net assets available for benefits for the years then ended, and the statement of accumulated plan benefits as of December 31, 2019, and the related statement of changes in accumulated plan 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 audits in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, 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, which was certified by State Street Bank and Trust Company, the trustee of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained certification from the trustee as of December 31, 2020 and 2019 and for the years then ended that the information provided to the plan administrator by the trustee is complete and accurate.

(Continued)

Disclaimer of Opinion

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

Other Matters

The supplemental Schedule H, Line 4i - Schedule of Assets (Held at End of Year) as of December 31, 2020 and Schedule H, Line 4j - Schedule of Reportable Transactions for the year ended December 31, 2020 are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for purposes of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules.

The Schedule H, Line 4i - Schedule of Assets (Held at End of Year) and Schedule H, Line 4j - Schedule of Reportable Transactions that accompany the Plan's financial statements do not disclose the historical cost of certain Plan assets held by State Street Bank and Trust Company. Disclosure of this information is required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

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

The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.


Crowe LLP

Oak Brook, Illinois
October 15, 2021

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
Net assets available for benefits		
Investments, at fair value	\$ 29,408,788	\$ 25,301,656
Employer contributions receivable	<u>-</u>	<u>827,766</u>
Net assets available for benefits	<u>\$ 29,408,788</u>	<u>\$ 26,129,422</u>

See accompanying notes to financial statements.

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years Ended December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
Additions		
Interest and dividend income	\$ 1,305,339	\$ 806,397
Net appreciation in fair value of investments	3,601,914	4,403,855
Employer contributions	<u>927,370</u>	<u>1,653,624</u>
 Total additions	 5,834,623	 6,863,876
Deductions		
Benefits paid directly to participants	2,192,314	2,219,842
Administrative expenses	<u>362,943</u>	<u>364,263</u>
 Total deductions	 <u>2,555,257</u>	 <u>2,584,105</u>
 Net increase	 3,279,366	 4,279,771
 Net assets available for benefits		
 Beginning of year	 <u>26,129,422</u>	 <u>21,849,651</u>
 End of year	 <u><u>\$ 29,408,788</u></u>	 <u><u>\$ 26,129,422</u></u>

See accompanying notes to financial statements.

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
STATEMENT OF ACCUMULATED BENEFITS
Year Ended December 31, 2019

Vested benefits	
Participants currently receiving payments	\$ 14,424,961
Terminated vested and active participants	<u>14,695,162</u>
Total vested benefits	29,120,123
Nonvested benefits	<u>17,041</u>
Actuarial present value of accumulated benefits	<u>\$ 29,137,164</u>

See accompanying notes to financial statements.

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
STATEMENT OF CHANGES IN ACCUMULATED BENEFITS
Year Ended December 31, 2019

Actuarial present value of accumulated benefits, beginning of year	\$ 29,104,997
Increase (decrease) during the year attributable to:	
Change in actuarial assumptions	(286,253)
Benefits accumulated and actuarial experience	857,587
Interest accumulated	1,680,675
Benefits paid	<u>(2,219,842)</u>
Net increase	<u>32,167</u>
Actuarial present value of accumulated benefits, end of year	<u><u>\$ 29,137,164</u></u>

See accompanying notes to financial statements.

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 1 - DESCRIPTION OF THE PLAN

The following description of Employees' Retirement Plan of Gaylord Hospital, Inc. (the Plan) is provided for only general information. Participants should refer to the Plan agreement for a more complete information.

General: The Plan is a frozen noncontributory defined benefit plan covering substantially all employees of Gaylord Hospital, Inc. (the Hospital) who completed one year of service and attained the age of 21 prior to October 31, 2004. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

In 2004, the Board of Directors of the Hospital approved an amendment to the Plan, which froze benefits earned under the Plan effective October 31, 2004. No employees are eligible or can commence participation in the Plan after October 31, 2004 and no additional benefits will be earned or accrued after October 31, 2004.

Pension Benefits: Employees with five or more years of service are entitled to annual pension benefits beginning at normal retirement age (65) equal to 1.6% of average annual compensation times years of service (not to exceed 30), plus 0.4% of average annual compensation in excess of \$21,875 times years of service (not to exceed 30). No compensation earned by a participant for service rendered after October 31, 2004 is included in a participant's average annual compensation utilized to calculate pension benefits. The Plan permits early retirement for participants with at least ten years of service at ages 55 to 64. If employees terminate before rendering five years of service, they forfeit the right to receive a portion of their accumulated plan benefits attributable to the Hospital's contributions. Employees may elect to receive the value of their accumulated plan benefits as a lump-sum distribution upon retirement or termination, or they may elect to receive their benefits as a joint and survivor annuity payable monthly from retirement.

Death and Disability Benefits: Death benefits are provided for a surviving spouse or beneficiary upon death of an active or terminated participant who dies after attaining eligibility and prior to receiving retirement benefits. Participants retiring from service with the Hospital on account of permanent disability, after having been credited with at least ten years of service and remaining disabled until normal retirement date, are fully vested and entitled to receive a monthly pension benefit payable immediately. The disability benefit shall be an amount equal to the participant's accrued benefit as of his or her disability date.

Administrative Expenses: The Plan's recordkeeping and custodial fees are paid by the Plan and are reflected in the financial statements as administrative expenses of the Plan. Investment management fees are charged to the Plan as a reduction of investment return and included in the net appreciation in fair value of investments reported by the Plan. All other expenses of the Plan are paid by the Hospital.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting: The accompanying financial statements are prepared 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 the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures, and actual results may differ from these estimates.

(Continued)

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Investment Valuation and Income Recognition: The Plan's investments are reported at fair value. Fair value is the price that would be received by the Plan for an asset or paid by the Plan to transfer a liability (an exit price) in an orderly transaction between market participants on the measurement date in the Plan's principal or most advantageous market for the asset or liability.

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

Benefit Payments: Benefit are recorded when paid.

Risks and Uncertainties: Investments are exposed to various risks such as interest rate, market, liquidity, and credit risks as well as the risks associated with the on-going Coronavirus pandemic. Due to the level of risk associated with certain Plan investments, it is at least reasonably possible that changes in the values of certain Plan investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

Plan contributions are made, and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

NOTE 3 - UNAUDITED INFORMATION - CERTIFIED INVESTMENTS

Substantially all information pertaining to the Plan's investments included in the financial statements, including interest, dividends, and net appreciation in fair value of investments was obtained or derived from information supplied to the Plan administrator and certified as complete and accurate by State Street Bank and Trust Company (State Street), the trustee of the Plan. This information has not been audited by independent accountants.

NOTE 4 - FAIR VALUE MEASUREMENTS

Fair value measurements are determined by maximizing the use of observable inputs and minimizing the use of unobservable inputs. The hierarchy places the highest priority on unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurements) and gives the lowest priority to unobservable inputs (Level 3 measurements). The three levels of inputs within the fair value hierarchy are defined as follows:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the Plan has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect the Plan's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

(Continued)

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 4 - FAIR VALUE MEASUREMENTS (Continued)

In some cases, a valuation technique used to measure fair value may include inputs from multiple levels of the fair value hierarchy. The lowest level of significant input determines the placement of the entire fair value measurement in the hierarchy.

The following presents the valuation methods and assumptions used by the Plan to estimate the fair values of investments.

Mutual Funds: The fair values of mutual fund investments are determined by obtaining quoted prices on nationally recognized securities exchanges (Level 1 inputs).

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

<u>2020</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Mutual funds	<u>\$ 29,408,788</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 29,408,788</u>
<u>2019</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Mutual funds	<u>\$ 25,301,656</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 25,301,656</u>

NOTE 5 - FUNDING POLICY

Employer contributions to the Plan are made in amounts approved by the Hospital's Board of Directors. Such contribution amounts must adhere to or exceed the minimum funding requirements under ERISA, as determined by the Plan's actuary. The Hospital's contributions to the Plan for the years ended December 31, 2020 and 2019 satisfied the minimum funding requirements of ERISA. Participant contributions are not permitted under the Plan.

NOTE 6 - PLAN TERMINATION

Although it has not expressed any intention to do so, the Hospital has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA and its related regulations. In the event the Plan terminates, the net assets of the Plan will be allocated among the participants and beneficiaries of the Plan in the order provided by ERISA.

Certain benefits under the Plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if the Plan terminates. Generally, the PBGC guarantees most vested normal age retirement benefits, early retirement benefits, and certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under the Plan, and the amount of benefit protection is subject to certain limitations.

Whether all participants receive their benefits should the Plan terminate at some future time will depend on the sufficiency, at that time, of the Plan's net assets to provide those benefits and may also depend on the financial condition of the Plan sponsor and the level of benefits guaranteed by the PBGC.

(Continued)

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 7 - ACTUARIAL PRESENT VALUE OF ACCUMULATED PLAN BENEFITS

Accumulated plan benefits are those future periodic payments, including lump-sum distributions that are attributable under the Plan's provisions to the service employees have rendered. Accumulated plan benefits include benefits expected to be paid to (a) retired or terminated employees or their beneficiaries, (b) beneficiaries of employees who have died, and (c) present employees or their beneficiaries. Benefits under the Plan are based on employees' compensation during their last five years of credited service. The accumulated plan benefits for active employees are based on their average compensation during the five years ending on the date as of which the benefit information is presented (valuation date). Benefits payable under all circumstances - retirement, death, disability, and termination of employment - are included, to the extent they are deemed attributable to employee service rendered to the valuation date.

The actuarial present value of accumulated plan benefits is determined by an actuary from the Transamerica Retirement Solutions Company and is that amount that results from applying actuarial assumptions to adjust the accumulated plan benefits to reflect the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as for death, disability withdrawal, or retirement) between the valuation date and the expected date of payment.

The significant actuarial assumptions used in the valuation as of December 31, 2019 were as follows:

Mortality: Pri-2012 mortality table, projected with Scale MP-2019

Retirement age: Graded from age 58 to 65

Investment return: The 2019 valuation included assumed an average rate of return of 6.0%.

For the year ended December 31, 2019, the significant change in actuarial assumptions is the impact of the updated mortality assumption to the PRI-2012 mortality table, projected with Scale MP-2019 from the RP-2014 mortality table with the MP-2018 improvement scale. The foregoing actuarial assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of accumulated plan benefits.

NOTE 8 - PLAN TAX STATUS

The Internal Revenue Service has determined and informed the Hospital by a letter dated July 24, 2015 that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code ("IRC"). Plan management believes that the Plan is designed and being operated in compliance with the applicable requirements of the IRC. Therefore, they believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2020 and 2019, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The plan administrator believes it is no longer subject to income tax examinations for years prior to 2017.

(Continued)

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 9 - DECEMBER 31, 2020 ACTUARIAL VALUATION (UNAUDITED)

The December 31, 2020 actuarial valuation was completed prior to the release of the financial statements. A summary of the actuarial valuation information provided by the plan's actuary, which has not been audited by independent accountants, is provided below for informational purposes.

The actuarial present value of accumulated plan benefits as of December 31, 2020 is as follows:

Actuarial present value of accumulated plan benefits	
Vested benefits	
Participants currently receiving payments	\$ 14,164,084
Other participants	<u>14,630,962</u>
Total vested benefits	28,795,046
Nonvested benefits	<u>82,756</u>
Actuarial present value of accumulated benefits	<u><u>\$ 28,877,802</u></u>

The change in actuarial present value of accumulated plan benefits for the year ended December 31, 2020 consists of the following:

Actuarial present value of accumulated plan benefits, as of December 31, 2019	\$ 29,137,164
(Decrease) increase during the year attributable to:	
Change in actuarial assumptions*	(75,970)
Benefits accumulated and actuarial experience	325,504
Interest accumulated	1,683,418
Benefits paid	<u>(2,192,314)</u>
Net decrease	<u>(259,362)</u>
Actuarial present value of accumulated benefits, as of December 31, 2020	<u><u>\$ 28,877,802</u></u>

*The significant actuarial assumptions changes are the impact of the updated mortality improvement scale from Scale MP-2019 to Scale MP-2020 and the impact of a change in the retirement assumption from a range of 58 to 65 to a range of 58 to 70.

NOTE 10 - PARTY-IN-INTEREST TRANSACTIONS

Parties-in-interest are defined under DOL regulations as any fiduciary of the plan, any party rendering service to the plan, the employer, and certain others. Amounts paid by the Plan to parties in interest included fees paid for recordkeeping and custodial services. Certain professional fees for the administration and audit of the Plan were paid by the Hospital. Various administrative functions are performed by officers or employees of the Hospital. No such officer or employee receives compensation from the Plan.

(Continued)

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
NOTES TO THE FINANCIAL STATEMENTS
December 31, 2020 and 2019

NOTE 11 - SUBSEQUENT EVENTS

Plan management has evaluated subsequent events for recognition and disclosure through October 15, 2021, which is the date the financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2020

Name of Plan Sponsor: Gaylord Hospital, Inc.
Employer Identification Number: 06-0646649
Three-Digit Plan Number: 001

		(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party			
Mutual Funds:				
	Pimco	Long Duration Total Return	**	\$ 7,903,639
	Vanguard	Long Term Investment	**	5,265,916
	Vanguard	Value Index I	**	4,140,778
	Vanguard	Growth Index I	**	4,121,958
	Artisan	Intl Value Fund	**	2,670,384
	MFS	International Growth R4	**	2,667,501
	Vanguard	Extended Market Index Adm	**	1,729,632
	Oppenheimer	Developing Markets Y	**	908,980
	Total mutual funds			<u>29,408,788</u>
	Total investments			<u>\$ 29,408,788</u>

** Historical cost information not available

See accompanying independent auditor's report.

EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
Year Ended December 31, 2020

Name of Plan Sponsor: Gaylord Hospital, Inc.
Employer Identification Number: 06-0646649
Three-Digit Plan Number: 001

(a) Identity of Party Involved	(b) Description of Asset (Including Interest Rate and Maturity in Case of Loan)	(c) Purchase Price	(d) Selling Price	(e) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or (Loss)
<u>Category (iii) - series of transactions in excess of 5% of Plan assets:</u>						
PIMCO	Long Duration Total Return	\$ 2,091,624	\$ -	**	\$ 2,091,624	**
		\$ -	\$ 1,213,309	**	\$ 1,213,309	**
Vanguard	Long Term Investment	\$ 3,039,757	\$ -	**	\$ 3,039,757	**
		\$ -	\$ 2,650,019	**	\$ 2,650,019	**
Vanguard	Growth Index I	\$ 325,618	\$ -	**	\$ 325,618	**
		\$ -	\$ 1,050,243	**	\$ 1,050,243	**

** Historical cost information not available

Note: There were no category (i), (ii) or (iv) reportable transactions during 2020. Columns for "Lease Rental" and "Expense Incurred with Transaction" are not applicable.

See accompanying independent auditor's report.

**Attachment to 2020 Form 5500 Schedule SB,
Line 26 – Schedule of Active Participant Data**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

.....Completed Years of Credited Service											
<u>Age</u>	0 to <u>1</u>	1 to <u>4</u>	5 to <u>9</u>	10 to <u>14</u>	15 to <u>19</u>	20 to <u>24</u>	25 to <u>29</u>	30 to <u>34</u>	35 to <u>39</u>	40 +	<u>Total</u>
0 – 24	0	0	0	0	0	0	0	0	0	0	0
25 – 29	0	0	0	0	0	0	0	0	0	0	0
30 – 34	0	0	0	0	0	0	0	0	0	0	0
35 – 39	0	0	0	0	0	0	0	0	0	0	0
40 – 44	0	5	6	2	0	0	0	0	0	0	13
45 – 49	0	4	11	5	0	0	0	0	0	0	20
50 – 54	0	4	8	5	2	1	0	0	0	0	20
55 – 59	0	2	8	11	7	1	0	0	0	0	29
60 – 64	0	5	0	1	2	3	1	0	0	0	12
65 – 69	0	2	3	1	1	2	0	1	0	0	10
70 & Up	<u>0</u>	<u>2</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>3</u>
Totals	0	24	37	25	12	7	1	1	0	0	107

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Statement of Actuarial Assumptions/Methods**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

A ACTUARIAL COST METHOD

The actuarial cost method used to determine the target normal cost, target liability and required contribution amounts for the plan is the Traditional Unit Credit Actuarial Cost Method. Under this method, both the target normal cost and target liability are based on the annual accrual of benefits as accruals occur each year.

The target liability for each active plan participant is equal to the actuarial present value of the participant's accrued benefit as of the valuation date. The total target liability of the plan is equal to the sum of such liabilities as determined for each active participant plus the actuarial present value of benefits being paid, or due to be paid, to retirees, beneficiaries and former participants with deferred vested benefits.

The target normal cost for each active participant is equal to the actuarial present value of the benefit expected to be earned during the year starting on the valuation date. The total target normal cost of the plan is the sum of the target normal costs for each active plan participant.

All employees who are plan participants on a valuation date are included in the actuarial valuation.

B ASSET VALUATION METHOD

The actuarial value of assets is equal to the market value of assets on the valuation date reduced by the sum of:

1. 66.67% of gains and losses of the prior year;
2. 33.33% of gains and losses of the second prior year.

Investment gains and losses are determined by the excess or deficiency of the expected return over the actual return on the market value (including employer contributions receivable for any given year). However, the expected return on assets may be limited by certain statutory interest rates.

The actuarial valuation of assets is further constrained to be not less than 90% or more than 110% of market value (including employer contributions receivable).

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Statement of Actuarial Assumptions/Methods**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

C INTEREST RATE METHODS

Target Liability Interest Rates

Segment rates for September prior to the valuation date as adjusted in accordance with Code Section 430(h)(2)(C)(iv) including the amendments made by the American Rescue Plan Act of 2021.

PBGC Interest Rates

Based on the alternative premium funding target and the Target Liability Interest Rates, unadjusted by Code Section 430(h)(2)(C)(iv).

Expected Return on Assets/
ASC 960-20 Interest Rate

6.00%

D ACTUARIAL ASSUMPTIONS

Pre- and Post-Retirement Mortality

Funding: Static Mortality Table in accordance with IRS Regulation 1.430(h)(3)(A).

Accounting (ASC 960-20): PRI-2012 Employee Tables with the Retiree and Contingent Survivor Tables for annuitants projected forward with Scale MP-2019 (previously, RP-2006 Employee and Healthy Annuitant Tables (i.e., the RP-2014 tables adjusted back to 2006) projected forward with scale MP-2018 for all years).

Salary Increases

Not Applicable.

IRC Maximum Benefit and
Compensation Limitations

Benefit Limit

\$230,000 for 2020 (previously, \$225,000).

Compensation Limit

Not Applicable.

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Statement of Actuarial Assumptions/Methods**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

D ACTUARIAL ASSUMPTIONS (cont'd)

Withdrawal Rates

Sample probabilities are as follows:

<u>Age</u>	<u>Rate</u>
25	14.3%
40	6.8%
54	3.9%
55	0.0%

Disability Rates

None assumed.

Retirement Age

Probabilities of retirements from active status are as follows:

<u>Age</u>	<u>Rate</u>
58-61	2.0%
62	7.5%
63-64	2.5%
65	100.0%

Terminated vested participants are assumed to retire at age 65.

Lump Sum Conversion

Under PPA, it is assumed that future lump sum distributions are determined using the target liability rates and the 417(e) applicable mortality table. For ASC 960-20, an interest rate of 5.00% and the 417(e) applicable mortality tables were used.

Form of Payment

It has been assumed that 60% of participants will elect a lump sum and 40% will elect an annuity upon retirement.

Marital Assumption

It has been assumed that 85% of all active participants are married. Husbands are assumed to be three years older than their wives. No dependents are assumed for non-married participants.

Plan Expenses

\$360,000.

ATTACHMENT TO THE 2020 SCHEDULE H OF FORM 5500
LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR) &
LINE 4j – SCHEDULE OF REPORTABLE TRANSACTIONS

Plan Sponsor: Gaylord Hospital, Inc.

Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc

Plan Year: January 1, 2020 to December 31, 2020

EIN: 06-0646649

Plan No.: 001

Item 4i- Schedule of Assets Held at End of Year

Page 13 of the attached auditor's report of the Plan for the plan year ending December 31, 2020 provides the schedule of assets information.

Item 4j- Schedule of Reportable Transactions

Page 14 of the attached auditor's report of the Plan for the plan year ending December 31, 2020 provides the schedule of reportable transactions.

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2020 This Form is Open to Public Inspection
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For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

► **Round off amounts to nearest dollar.**

► **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan EMPLOYEES' RETIREMENT PLAN OF GAYLORD HOSPITAL, INC.	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF GAYLORD HOSPITAL, INC.	D Employer Identification Number (EIN) 06-0646649	
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☒ 101-500 ☐ More than 500	

Part I	Basic Information		
1	Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2020</u>		
2	Assets:		
	a Market value	2a	26108669
	b Actuarial value	2b	24445756
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment.....	136	15127672
	b For terminated vested participants.....	145	7268648
	c For active participants	107	6930310
	d Total.....	388	29326630
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... ☐		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	4b	
5	Effective interest rate	5	5.68 %
6	Target normal cost.....	6	360000

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	 Signature of actuary NICOLE DEVOE, A.S.A., E.A.	09/23/2021 Date 20-06880
	Type or print name of actuary TRANSAMERICA	Most recent enrollment number (508) 903-6014
	Firm name PO Box 428 Cedar Rapids, IA 52406-0428 Address of the firm	Telephone number (including area code)

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2020
v. 200204

2021-09-16T11:07:04.958-05:00

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>25.01</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		0
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.48</u> %		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		0
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages

14 Funding target attainment percentage	14	83.30 %
15 Adjusted funding target attainment percentage	15	80.34 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	76.83 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04-14-2020	392054				
07-10-2020	267658				
10-13-2020	267658				
Totals ▶			18(b)	927370	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	902349

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.75 %	2nd segment: 5.50 %	3rd segment: 6.27 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age				22 64
23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	☒ Yes ☐ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29).....	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6).....	31a	360000	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	4898894	459941	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....	34	819941	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	0	0
36 Additional cash requirement (line 34 minus line 35)	36	819941	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	902349	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	82408	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:	
a Schedule elected	☐ 2 plus 7 years ☒ 15 years
b Eligible plan year(s) for which the election in line 41a was made	☐ 2008 ☐ 2009 ☒ 2010 ☒ 2011

Schedule C, Line 2(h) Formula Descriptions

Employees' Retirement Plan of Gaylord Hospital, Inc.
 EIN No.: 06-0646649, Plan No. 001
 Plan Year Ending: 12/31/2020

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

NATIONAL FINANCIAL SERVICES 04-3523567

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

Fund Family	Fund Name	Start Date	End Date	Revenue to National Financial Services
ARTISAN FUNDS	ARTISAN INTERNATIONAL VALUE INVESTOR	1/1/2020	12/31/2020	1.092
INVESCO	INVESCO DEVELOPING MARKETS Y	1/1/2020	12/31/2020	0.700
MFS	MFS INTERNATIONAL GROWTH R4	1/1/2020	12/31/2020	0.420

**Attachment to 2020 Form 5500 Schedule SB,
Line 15 – Reconciliation of Differences Between Valuation Results and Amounts Used to
Calculate AFTAP**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.:001**

2020 AFTAP for the Employees' Retirement Plan of Gaylord Hospital, Inc.

The 2020 AFTAP is 80.34% as summarized below:

1. Adjusted plan assets:	
a. Actuarial value of plan assets*	\$ 24,445,756
b. Carryover credit balance	0
c. Prefunding credit balance	0
d. Total credit balance required to be subtracted from plan assets: \$0 if (a) ≥ 100% of (2)(a), otherwise (b)+(c)	0
e. Annuity purchases for nonhighly-compensated employees in prior two plan years	0
f. Adjusted plan assets: (a) – (d) + (e)	\$ 24,445,756
2. Adjusted funding target:	
a. Funding target	\$ 30,424,106
b. Adjusted funding target: (a) + (1)(e)	\$ 30,424,106
3. 2020 AFTAP: (1)(f) ÷ (2)(b)	80.34%

** Includes only contributions for the 2019 plan year that were actually made on or before the date of this certification.*

The January 1, 2020 valuation was updated to reflect the provisions of the American Rescue Plan Act ("ARPA"). The update did not have a material impact on the administration of the plan. The AFTAP shown above was certified on September 24, 2020 prior to the revision of the valuation report for ARPA.

**Attachment to 2020 Form 5500 Schedule SB,
Line 22 – Description of Weighted Average Retirement Age**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.:001**

The average retirement age for Line 22 was calculated by creating a hypothetical life table with retirement as the only decrement, and then computing the average retirement age for the table.

x	q_x^r	l_x	${}_{x-55}p_{55} = l_x / l_{55}$	$q_x^r * l_x / l_{55}$	$x * q_x^r * l_x / l_{55}$
58	0.02	1,000,000	1	0.02	1.16
59	0.02	980,000	0.98	0.0196	1.1564
60	0.02	960,400	0.9604	0.01921	1.15248
61	0.02	941,192	0.94119	0.01882	1.14825424
62	0.075	922,368	0.92237	0.06918	4.28901194
63	0.025	853,191	0.85319	0.02133	1.34377511
64	0.025	831,861	0.83186	0.0208	1.33097725
65	1	811,064	0.81106	0.81106	52.7191772

Average age at retirement 64.30

Rounded for Schedule SB item 22 64

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Summary of Plan Provisions**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

Effective Date

Effective April 1, 1965. Most recently restated effective January 1, 2014.

Eligibility

Completion of 1,000 hours in the Plan Year of hire will result in an employee becoming eligible for participation on the first of the month coinciding with or next following the Plan Year of hire. Otherwise, participation begins on the January 1 following the first Plan Year in which the employee completes 1,000 hours of service.

After October 31, 2004 no new participants shall be added to the Plan.

Benefit Service

A year of Benefit Service is credited for every 1,000 compensated hours in each Plan Year. For compensated hours of less than 1,000 no Benefit Service is given. Total years of Benefit Service is limited to 30 years.

However, no Benefit Service will be credited after October 31, 2004. Participants will continue to earn Service for vesting or eligibility purposes after October 31, 2004.

Base Compensation

Base Compensation is defined as:

- (a) Total earnings reported for federal income tax purposes except severance pay and any other extraneous form of compensation, and
- (b) Additional amounts contributed to tax-sheltered plans.

Average Base Compensation

The highest average Base Compensation of any (60) sixty consecutive months preceding termination.

Compensation earned after October 31, 2004 will not be used in the average base compensation calculation.

Accrued Benefit

The product of (c) and the sum of (a) and (b):

- (a) 1.6% of Average Base Compensation up to \$21,875,
- (b) 2.0% of Average Base Compensation in excess of \$21,875,
- (c) Years of Benefit Service, up to 30.

Benefits are frozen as of October 31, 2004.

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Summary of Plan Provisions**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

<u>Normal Retirement</u>	Eligible at age 65 or 5 years of service, if later. The Normal Retirement Benefit is the Accrued Benefit.
<u>Early Retirement</u>	Eligible at age 55 with 10 years of service. The Early Retirement Benefit is the accrued Normal Retirement Benefit reduced 0.5% for each month that commencement precedes the first of the month coinciding with or next following the participant reaching age 62.
<u>Late Retirement Benefit</u>	Greater of Accrued Benefit as of Late Retirement Date or actuarially increased Normal Retirement Benefit.
<u>Vesting</u>	A participant becomes 100% vested upon completion of five years of service.
<u>Pre-Retirement Death Benefit</u>	<p>The surviving spouse becomes eligible upon the death of an employee or former employee who completed 5 or more years of Vesting Service. If the participant is unmarried with dependents, dependents receive the value of any benefits as if the participant was married with a spouse of the same age as the participant.</p> <p>The surviving spouse will receive the benefit that would have been paid if the employee or former employee had retired on the day prior to his death and had elected a 50% Joint & Survivor option. Benefits to surviving spouses of employees or former employees who have died prior to age 55 will be deferred to the date the decedent would have turned age 55. In addition, surviving spouses of terminated vested participants are also entitled to the lump sum value of the vested benefit less the value of any survivor benefit mentioned above.</p>
<u>Disability Retirement</u>	Eligible if disability is permanent and total. Accrued Benefit as of date of disability first payable upon Normal Retirement eligibility.

**Attachment to 2020 Form 5500 Schedule SB,
Part V – Summary of Plan Provisions**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

Form of Payment

The normal form of payment is a life only benefit for single employees and a 50% Joint & Survivor benefit for married employees. Optional forms include life annuity, 100%, 75%, 67% or 50% Joint and Survivor benefit, a life annuity guaranteed for the first 10 years, Social Security level income or lump sum. Automatic lump sums are payable immediately, without participant or spousal consent, if the present value is \$1,000 or less.

Lump sums and the Social Security level income option are determined on an actuarial equivalent basis using the 417(e) applicable mortality and interest rates. Other optional forms of payment are determined by tabular factors as defined in the plan document.

Sample Factors:

Age of Beneficiary	50% J&S	67 % J&S	75 % J&S	100 % J&S	10 C&C
10-14 years older	.95	.93	.93	.90	.91
0-4 years older	.88	.85	.84	.79	.91
10-14 years younger	.82	.78	.76	.69	.91

Summary of Plan Changes

None.

Summary of Significant Events

None.

Plan Status

Frozen.

ATTACHMENT TO THE 2020 SCHEDULE H OF FORM 5500
LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR) &
LINE 4j – SCHEDULE OF REPORTABLE TRANSACTIONS

Plan Sponsor: Gaylord Hospital, Inc.

Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc

Plan Year: January 1, 2020 to December 31, 2020

EIN: 06-0646649

Plan No.: 001

Item 4i- Schedule of Assets Held at End of Year

Page 13 of the attached auditor's report of the Plan for the plan year ending December 31, 2020 provides the schedule of assets information.

Item 4j- Schedule of Reportable Transactions

Page 14 of the attached auditor's report of the Plan for the plan year ending December 31, 2020 provides the schedule of reportable transactions.

**Attachment to 2020 Form 5500 Schedule SB,
Line 32 – Schedule of Amortization Bases**

**Plan Name: Employees' Retirement Plan of Gaylord Hospital, Inc.
E.I.N.: 06-0646649 Plan No.: 001**

Amortization Schedule

(a) <u>Year</u>	(b) <u>Type</u>	(c) <u>Present Value</u>	(d) <u>Years Left</u>	(e) <u>Payment</u>
2014	Shortfall	0	1	0
2015	Shortfall	0	2	0
2016	Shortfall	0	3	0
2017	Shortfall	0	4	0
2018	Shortfall	0	5	0
2019	Shortfall	0	6	0
2020	Shortfall	<u>4,898,894</u>	15	<u>459,941</u>
Total		\$ 4,898,894		\$ 459,941