Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

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

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/1989

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)
CHILDREN'S HOSPITAL COLORADO

13123 EAST 16TH AVENUE B105
AURORA, CO 80045

2b Employer Identification Number (EIN) 84-0166760

2c Plan Sponsor's telephone number 720-777-6902

2d Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/11/2022	BETSY RODRIGUEZ
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	10740
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)**	7836
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	7949
b	Retired or separated participants receiving benefits	**6b**	328
c	Other retired or separated participants entitled to future benefits	**6c**	3815
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	12092
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	7
f	Total. Add lines **6d** and **6e**	**6f**	12099
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	11608
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	1189
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

2F 2G 2L 2M 2S 2T

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 2 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **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 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
CHILDREN'S HOSPITAL COLORADO

D Employer Identification Number (EIN)
84-0166760

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

1 Coverage Information:

(a) Name of insurance carrier
GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
84-0467907	7692	95824-01	3141	01/01/2021	12/31/2021

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	64469760
5	Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	66268552
c	Additions: (1) Contributions deposited during the year	7c(1)	3656203		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	1033441		
	(4) Transferred from separate account	7c(4)	8986697		
	(5) Other (specify below)	7c(5)	2915199		
	▶ LOAN PAYMENTS, FORFEITURES				
	(6) Total additions			7c(6)	16591540
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	82860092
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	8468539		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)	9921793		
	(4) Other (specify below)	7e(4)	0		
	▶				
	(5) Total deductions			7e(5)	18390332
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	64469760

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
CHILDREN'S HOSPITAL COLORADO

D Employer Identification Number (EIN)
84-0166760

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

1 Coverage Information:

(a) Name of insurance carrier
LINCOLN NATIONAL LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
35-0472300	65676	193151	31	01/01/2021	12/31/2021

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	821968
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	808588
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)	29140		
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	29140
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	837728
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	15760		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	15760
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	821968

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2021** **This Form is Open to Public Inspection.**

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan	**B** Three-digit plan number (PN) ▶
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN	002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
CHILDREN'S HOSPITAL COLORADO	84-0166760

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

GREAT WEST LIFE AND ANNUITY COMPANY

8515 EAST ORCHARD ROAD
GREENWOOD VILLAGE, CO 80111

(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?
64	RECORDKEEPER	283700	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

ADVISED ASSET GROUP

8515 EAST ORCHARD ROAD
GREENWOOOD VILLAGE, CO 80111

(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?
28	INVESTMENT MANAGEMENT	197713	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [ ]

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

MUTUAL OF AMERICA

84-0166760

(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?
13	SERVICE PROVIDER	2222	Yes [X] No [ ]	Yes [ ] No [X]	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)

LINCOLN NATIONAL CORPORATION

35-1140070

(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?
13	SERVICE PROVIDER	300	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [ ]

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
CHILDREN'S HOSPITAL COLORADO

D Employer Identification Number (EIN)
84-0166760

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	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	14983452	462738
(2) Participant contributions	1b(2)	495364	697218
(3) Other	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	9779668	9782810
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	660313240	784943717
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	67079055	66025522
(15) Other	1c(15)	0	0

			(a) Beginning of Year	**(b)** End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)	0	0
	(2) Employer real property	1d(2)	0	0
e	Buildings and other property used in plan operation	1e	0	0
f	Total assets (add all amounts in lines 1a through 1e)	1f	752650779	861912005
	Liabilities			
g	Benefit claims payable	1g	0	0
h	Operating payables	1h		
i	Acquisition indebtedness	1i	0	0
j	Other liabilities	1j	0	0
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	752650779	861912005

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)	17592473	
	(B) Participants	2a(1)(B)	39279343	
	(C) Others (including rollovers)	2a(1)(C)	6552915	
	(2) Noncash contributions	2a(2)	0	
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		63424731
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
	(B) U.S. Government securities	2b(1)(B)	0	
	(C) Corporate debt instruments	2b(1)(C)	0	
	(D) Loans (other than to participants)	2b(1)(D)	0	
	(E) Participant loans	2b(1)(E)	511666	
	(F) Other	2b(1)(F)	1070090	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		1581756
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)	0	
	(B) Common stock	2b(2)(B)	0	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	38736213	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		38736213
	(3) Rents	2b(3)		0
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	0	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)	0	
	(B) Other	2b(5)(B)	0	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		0
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		65629032
c Other income	2c		811630
d Total income. Add all **income** amounts in column (b) and enter total	2d		170183362
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	60060179	
(2) To insurance carriers for the provision of benefits	2e(2)	0	
(3) Other	2e(3)	0	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		60060179
f Corrective distributions (see instructions)	2f		915
g Certain deemed distributions of participant loans (see instructions)	2g		377107
h Interest expense	2h		0
i Administrative expenses: **(1)** Professional fees	2i(1)	0	
(2) Contract administrator fees	2i(2)	286222	
(3) Investment advisory and management fees	2i(3)	197713	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		483935
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		60922136
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		109261226
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

(1) [X] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [ ] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: ERNST & YOUNG **(2)** EIN: 34-6565596

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

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

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a	X		4454

			Yes	No	Amount
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e	Was this plan covered by a fidelity bond?	**4e**	X		5000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l	Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ No

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

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

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

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

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

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection.

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
CHILDREN'S HOSPITAL COLORADO 403(B) PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
CHILDREN'S HOSPITAL COLORADO

D Employer Identification Number (EIN)
84-0166760

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): 20-3691708

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 |

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

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

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

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

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

6	a	Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
	b	Enter the amount contributed by the employer to the plan for this plan year	6b	
	c	Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

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

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

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

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

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

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

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

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

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

19 If the total number of participants is 1,000 or more, complete lines (a) through (c)

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

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

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

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

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

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

☐ Yes.

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

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

☐ No. Other. Provide explanation _____

Financial Statements and Supplemental Schedules

Children's Hospital Colorado 403(b) Plan
As of December 31, 2021 and 2020, and
for the Year Ended December 31, 2021
With Report of Independent Auditors

Ernst & Young LLP



Children's Hospital Colorado 403(b) Plan

Financial Statements and Supplemental Schedules

As of December 31, 2021 and 2020, and for the Year Ended December 31, 2021

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Ernst & Young LLP
370 17th Street
Suite 4800
Denver, CO 80202

Tel: +1 720 931 4000
Fax: +1 720 931 4444
ey.com

Report of Independent Auditors

The Retirement Benefits Committee
Children's Hospital Colorado Health System

Scope and Nature of the ERISA Section 103(a)(3)(C) Audit for the 2021 Financial Statements

We were engaged to perform an audit of the financial statements of Children's Hospital Colorado 403(b) Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statement of net assets available for benefits as of December 31, 2021, and the related statement of changes in net assets available for benefits for the year then ended, and the related notes (collectively referred to as the "financial statements").

Management, having determined it is permissible in the circumstances, has elected to have the audit of the financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audit need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained a certification from a qualified institution as of December 31, 2021, and for the year then ended, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Disclaimer of Opinion on the 2021 Financial Statements

We do not express an opinion on the accompanying financial statements of the Plan. Because of the significance of the matter described in the Basis for Disclaimer of Opinion on the 2021 Financial Statements section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the financial statements.

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Basis for Disclaimer of Opinion on the 2021 Financial Statements

The Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009. Accordingly, we were unable to apply auditing procedures sufficient to determine the extent to which the financial statements may have been affected by these conditions. Further, as discussed in Note 1, the Plan has excluded from investments in the accompanying statement of net assets available for benefits certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009, as permitted by the Department of Labor's Field Assistance Bulletin No. 2009-02, *Annual Reporting Requirements for 403(b) Plans*. The investment income and distributions related to such accounts has also been excluded from the accompanying statement of changes in net assets available for benefits. The amount of these excluded annuity contracts and custodial accounts and the related income and distributions are not determinable. Accounting principles generally accepted in the United States of America require that these accounts and the related income and distributions be included in the financial statements.

Responsibilities of Management for the 2021 Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the 2021 Financial Statements

Our responsibility is to conduct an audit of the Plan's financial statements in accordance with auditing standards generally accepted in the United States of America and to issue an auditor's report. However, because of the matter described in the Basis for Disclaimer of Opinion on the 2021 Financial Statements section of our report, we were not able to obtain sufficient appropriate evidence to provide a basis for an audit opinion on these financial statements.

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We are required to be independent of the Plan, and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit.

Other Matters

Supplemental Schedules Required by ERISA

The supplemental schedules of assets (held at end of year) as of December 31, 2021 and delinquent participant contributions for the year then ended (referred to as the "supplemental schedules"), are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements.

Because of the significance of the matter described in the Basis for Disclaimer of Opinion on the 2021 Financial Statements section of our report, it is inappropriate to and we do not express an opinion on the supplemental schedules.

Auditor's Report on the 2020 Financial Statements

We were engaged to audit the financial statements of the Plan as of and for the year ended December 31, 2020. As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA, the plan administrator instructed us not to perform and we did not perform any auditing procedures with respect to the investment information certified by a qualified institution. Further, the Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts issued to current and former employees prior to January 1, 2009. In our report dated October 11, 2021, we indicated that because of the significance on the information that we did not audit, we were unable to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion and accordingly, we did not express an opinion on the 2020 financial statements.

Ernst & Young LLP

October 5, 2022

A member firm of Ernst & Young Global Limited

Children's Hospital Colorado 403(b) Plan

Statements of Net Assets Available for Benefits

	December 31	
	2021	**2020**
Assets		
Investments, at fair value	**$ 785,677,511**	$ 660,313,241
Investments, at contract value	**65,291,728**	67,079,054
Total investments	**850,969,239**	727,392,295
Receivables:		
Notes receivable from participants	**9,782,810**	9,779,668
Participant contributions	**697,218**	495,364
Employer contributions	**462,738**	14,983,452
Total receivables	**10,942,766**	25,258,484
Net assets available for benefits	**$ 861,912,005**	$ 752,650,779

See accompanying notes.

Children's Hospital Colorado 403(b) Plan

Statement of Changes in Net Assets Available for Benefits

Year Ended December 31, 2021

Additions	
Investment income:	
Interest and dividends	$ 40,317,969
Net appreciation in fair value of investments	65,629,028
Other income	811,634
Total investment income	106,758,631
Contributions:	
Participant	39,279,343
Employer	17,592,473
Rollovers	6,552,915
Total contributions	63,424,731
Total additions	170,183,362
Deductions	
Benefit payments	60,438,201
Administrative expenses	483,935
Total deductions	60,922,136
Net increase in net assets available for benefits	109,261,226
Net assets available for benefits, beginning of year	752,650,779
Net assets available for benefits, end of year	$ 861,912,005

See accompanying notes.

Children's Hospital Colorado 403(b) Plan

Notes to Financial Statements

December 31, 2021

1. Description of the Plan

The following description of the Children's Hospital Colorado 403(b) Plan (the Plan) provides only general information. Children's Hospital Colorado (the Hospital) is the Plan sponsor. Participants should refer to the summary Plan description and Plan document for a more complete description of the Plan's provisions.

The Plan is a defined 403(b) contribution plan created for the benefit of the employees and beneficiaries of the Hospital. Effective January 1, 2002, all employees of the Hospital are eligible to participate in the Plan. The Retirement Benefits Committee of Children's Hospital Colorado is responsible for the general administration of the Plan. Empower Trust Company, LLC is the trustee of the Plan. Empower Retirement, LLC is record-keeper for the Plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Legacy Contracts

The Plan holds legacy annuity contracts and custodial accounts with providers issued to current and former participants prior to January 1, 2009. The legacy contracts are frozen, and no current contributions are being made. Certain of the net assets available for benefits, investment income, distributions, and administrative expenses related to the legacy contracts have been excluded from the accompanying financial statements, while others have been included. As of December 31, 2021, the value of such contracts included in net assets available for benefits was $3,541,537.

Contributions

Participants can elect to defer up to 80% of their pretax compensation, as defined in the Plan document. The Hospital matched employee contributions on a discretionary basis. During 2021, the discretionary employer match ranged from 3% to 6% of the participant's deferral into the Plan. In February 2021, the Hospital paid a one-time 3% lump-sum discretionary employer match of $14,787,169, which was recorded as an employer contribution receivable in the statement of net assets available for benefits as of December 31, 2020.

Vesting

Participants are 100% vested in their salary deferral and rollover contributions at all times. Participants vest in employer matching and discretionary contributions based upon a graduated vesting schedule and become fully vested upon completion of five years of service. A participant also becomes fully vested in employer matching and discretionary contributions upon attainment

1. Description of the Plan (continued)

of normal retirement age, total and permanent disability, or death. Forfeitures of non-vested amounts are used to reduce the Hospital's matching contributions for the Plan year in which such forfeitures occur. During 2021, the Hospital used approximately $3.0 million in forfeitures to reduce employer contributions. Forfeiture account balances were $144,907 and $652,494 as of December 31, 2021 and 2020, respectively.

Participant Loans

Notes receivable from participants represent participant loans. Participants may borrow a minimum of $1,000 from their fund accounts and up to 50% of their fund account balance, not to exceed a total of $50,000, less outstanding loan balances. The loans are secured by the balance in the participant's fund account and bear interest at a reasonable rate determined by the Plan administrator. Principal and interest payments are made through payroll deductions. Loans must be repaid within five years, except for loans for the purchase of a primary residence, which, prior to October 1, 2014, were required to be repaid within 20 years, but now must be repaid within 15 years.

Benefit Payments

Participants are entitled to distributions from the Plan upon death, disability, normal or early retirement, or other termination of employment. Upon termination of service, a participant is entitled to receive his or her vested benefits under the Plan. The forms of distribution include (1) a qualified joint and survivor annuity if the participant is married on the date his or her service with the employer terminates, (2) a single-life annuity if the participant is unmarried on the date his or her service with the employer terminates, or (3) a lump-sum distribution or another form of annuity if the participant elects it in a timely and proper manner.

Additionally, participants may request a distribution of vested portions of their accounts due to financial hardship, as defined in the Plan document.

1. Description of the Plan (continued)

Direct Transfer and Rollover Contributions

The Plan accepts direct transfer and rollover contributions from qualified plans, such as 401(k), profit-sharing, or pension plans, in addition to qualified annuity plans, 403(b) plans, or annuity contracts, and governmental 457(b) plans. The Plan also accepts direct transfers of after-tax contributions from other tax-qualified plans and rollovers from individual retirement accounts. These contributions are fully vested at all times and are subject to the same distribution restrictions that apply to other plan contributions.

Plan Termination

Although it has not expressed any intent to do so, the Hospital reserves the right to amend or terminate the Plan at any time. If the Plan is terminated for any reason, participants will automatically become fully vested in their accounts regardless of their years of service, subject to the provisions of ERISA.

Administrative Expenses

The Plan's administrative expenses are paid by either the Plan or the Hospital, as provided by the Plan's provisions. Administrative expenses paid by the Plan include record-keeping and trustee fees. Expenses relating to purchases, sales, or transfers of the Plan's investments are charged to the particular investment fund to which the expenses relate. All other administrative expenses of the Plan are paid by the Hospital. Expenses that are paid by the Hospital are excluded from these financial statements.

2. Summary of Accounting Policies

Basis of Accounting

The accompanying financial statements of the Plan are prepared on the accrual basis of accounting, in accordance with accounting principles generally accepted in the United States.

Benefits Paid to Participants

Benefit payments are recorded when paid.

2. Summary of Accounting Policies (continued)

Investment Valuation and Income Recognition

Investments held by the Plan (except for fully benefit-responsive investment contracts) are stated at fair value. See Note 5 for further discussion and disclosures related to fair value measurements.

Dividends are recorded on the ex-dividend date. Interest income is recorded on the accrual basis. Purchases and sales of securities are recorded on a trade-date basis.

Net realized and unrealized gains and losses on investments bought, sold and held during the year are reflected on the accompanying statement of changes in net assets available for benefits as net appreciation in fair value of investments.

When it is determined to be in the participants' best interest, the Plan retains investments that provide revenue sharing payments. Revenue sharing payments are applied to the accounts of the participants holding such investments and are reflected on the accompanying statement of changes in net assets available for benefits as other income.

Use of Estimates

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates that affect the amounts reported in the financial statements, accompanying notes, and supplemental schedules. Actual results could differ from those estimates.

Notes Receivable From Participants

Notes receivable from participants represent participant loans that are recorded at their unpaid principal balance, plus any accrued but unpaid interest. Interest income on notes receivable from participants is recorded when it is earned. Related fees are recorded as administrative expenses and are expensed when they are incurred. No allowance for credit losses has been recorded as of December 31, 2021 or 2020. If a participant ceases to make loan repayments and the Plan administrator deems the participant loan to be a distribution, the participant loan balance is reduced and a benefit payment is recorded.

3. Investments

Investment information disclosed in the accompanying financial statements, and supplemental schedule, including notes receivable from participants at December 31, 2021 and 2020, and net appreciation in fair value of investments, investment income, other income, and interest on notes receivable from participants for the year ended December 31, 2021, was obtained or derived from information supplied to the Plan administrator and certified as complete and accurate by Great-West Trust Company, LLC (now, Empower Trust Company, LLC), the trustee of the Plan.

4. Fair Value Measurements

The Plan follows Accounting Standards Codification (ASC) 820, *Fair Value Measurement*, to value its financial assets and liabilities, except those reported at contract value. As defined in ASC 820, fair value is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In order to increase consistency and comparability in fair value measurements, ASC 820 establishes a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels, which are described below:

Level 1 – Level 1 inputs include quoted prices (unadjusted) in active markets that are accessible at the measurement date for assets or liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs. The Plan's investments in mutual funds and pooled investment accounts are stated at fair value based on quoted market prices.

Level 2 – Level 2 inputs include observable prices that are based on inputs not quoted on active markets but corroborated by market data.

Level 3 – Unobservable inputs are used when little or no market data is available. The fair value hierarchy gives the lowest priority to Level 3 inputs.

In determining fair value, the Plan utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible, as well as considers counterparty credit risk in its assessment of fair value.

4. Fair Value Measurements (continued)

Financial assets carried at fair value are classified in the tables below in one of the three categories:

	Fair Value Measurements as of December 31, 2021			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds	**$ 783,281,731**	**$ –**	**$ –**	**$ 783,281,731**
Pooled investment accounts	**2,395,780**	**–**	**–**	**2,395,780**
Total assets at fair value	**$ 785,677,511**	**$ –**	**$ –**	**$ 785,677,511**

	Fair Value Measurements as of December 31, 2020			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds	$ 658,016,596	$ –	$ –	$ 658,016,596
Pooled investment accounts	2,296,645	–	–	2,296,645
Total assets at fair value	$ 660,313,241	$ –	$ –	$ 660,313,241

5. Annuity Contracts

The Plan provides participants with two fixed annuity contract investment options that are fully benefit responsive – one through Lincoln Financial Group and one through Empower Annuity Insurance Company of America. These contracts meet the fully benefit-responsive investment contract criteria and are, therefore, reported at contract value. The funds are supported by the Lincoln Financial Group fixed account and Empower Annuity Insurance Company of America general account, respectively, and have no maturity date. If all participants were eligible for a distribution of their full accounts from the Plan on the reporting date, the amount payable on demand on the reporting date would be the contract value.

The crediting interest rate is declared periodically, but not less than annually, and may apply to the entire contract value or separately to amounts accumulated in separate time periods. Crediting rates are set in response to the following factors: (1) the totality of investments previously made by participants, (2) their anticipated payout timing requirements, (3) the current investment climate, (4) contractual minimum interest rate guarantees, (5) competitive requirements, and (6) required

5. Annuity Contracts (continued)

return on invested capital supporting the product. The average yield earned by the Plan for the years ended December 31, 2021 and 2020, was 4.00% for the Lincoln Financial Group contract and 0.90% and 1.05%, respectively, for the Empower Annuity Insurance Company of America contract. These are the same average yields credited to participants.

The Lincoln Financial Group and Empower Annuity Insurance Company of America contracts do not specify any events that would limit the ability of the Plan to transact at contract value with the issuer or any events that would allow the issuer to terminate the contract and settle for an amount different from contract value. The contract provides payment options of the contract value for surrendering the contract; however, the Plan sponsor does not intend to surrender the contract.

6. Income Tax Status

The underlying volume submitter specimen plan has received an advisory letter from the Internal Revenue Service (IRS) dated March 31, 2017, stating that the written form of the underlying specimen plan is qualified under Section 403(b) of the Internal Revenue Code (the Code). Any employer adopting this form of the plan will be considered to have a plan qualified under Section 403(b) of the Code and, therefore, the related custodial accounts are tax-exempt. Once qualified, the Plan is required to operate in conformity with the Code to maintain its qualified status. The Plan administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believe the Plan is qualified and the related trust is tax-exempt.

Accounting principles generally accepted in the United States require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. As of December 31, 2021, there are no uncertain positions taken or expected to be taken by the Plan and no interest or penalties have been recognized related to uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

7. Related Parties

Certain investments are managed by Empower Trust Company, LLC, the trustee and custodian, and, therefore, qualify as party-in-interest transactions for which a statutory exemption exists.

8. Risks and Uncertainties

Investments are exposed to various risks, such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investments, it is reasonably possible that changes in the fair value of investments will occur in the near term and that such changes could materially affect the amounts reported in participant account balances and on the statements of net assets available for benefits.

9. Subsequent Events

Management evaluated subsequent events through October 5, 2022, the date the accompanying financial statements were available to be issued.

Effective March 5, 2022, the Plan was restated. Roth contributions and in-plan roth rollover and transfers were added as contribution options to the Plan.

Supplemental Schedules

Children's Hospital Colorado 403(b) Plan

EIN 84-0166760 Plan #002

Schedule H, Line 4a – Schedule of Delinquent Participant Contributions

Year Ended December 31, 2021

Participant Contributions Transferred Late to Plan	Total that Constitutes Non-exempt Prohibited Transactions			
Check here if Late Participant Loan Repayments are included: ☐	Contributions Not Corrected	Contributions Corrected Outside Voluntary Fiduciary Correction Program (VFCP)[1]	Contributions Pending Correction in VFCP	Total Fully Corrected Under VFCP and Prohibited Transaction Exemption (PTE) 2002–51
$ 4,454	$ –	$ 4,454	$ –	$ –

[1] Represents delinquent participant contributions from various 2021 pay periods. The Company transmitted lost earnings to the Plan on April 5, 2021 and February 11, 2022.

Children's Hospital Colorado 403(b) Plan

EIN 84-0166760 Plan #002

Schedule H, Line 4(i) – Schedule of Assets
(Held at End of Year)

December 31, 2021

Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Identity of Issue, Borrower, Lessor, or Similar Party**	Current Value
Mutual funds:		
AB VPS LARGE CAP GROWTH PORT	LINCOLN	$ 3,122
AMERICAN CENTURY MID CAP VALUE INST	EMP	18,640,502
AMERICAN CENTURY VP BALANCED	LINCOLN	10,912
AMERICAN FUNDS AMER BALANCED A	EMP	16,970,722
AMERICAN FUNDS GROWTH FUND	LINCOLN	1,417
AMERICAN FUNDS EUROPACIFIC GROWTH FUND A	EMP	53,942,871
AMERICAN FUNDS INTERNATIONAL	LINCOLN	226
COLUMBIA STRATEGIC INCOME Z	EMP	4,517,884
DELAWARE VIP REIT SERIES	LINCOLN	1,303
DELAWARE VIP SMID CAP CORE	LINCOLN	639
FIDELITY ASSET MANAGER	LINCOLN	12,536
FIDELITY 500 INDEX	EMP	116,665,853
FIDELITY CONTRAFUND K6	EMP	47,359,104
FIDELITY INTERNATIONAL INDEX	EMP	19,166,889
FIDELITY MID CAP INDEX	EMP	65,364,385
FIDELITY SMALL CAP INDEX	EMP	17,565,822
FIDELITY US BOND INDEX	EMP	50,793,398
FIDELITY GROWTH PORTFOLIO	LINCOLN	124,111
FRANKLIN SMALL CAP GROWTH R6	EMP	16,378,997
GOLDMAN SACHS INTL SM CAP INSIGHTS INSL	EMP	2,947,539
INVESCO OPPENHEIMER DEVELOPING MRKTS R6	EMP	10,038,185
INVESCO REAL ESTATE R5	EMP	12,682,544
JANUS ASPEN GLOBAL RESEARCH	LINCOLN	363
JPMORGAN SMALL CAP VALUE R6	EMP	6,007,494
LINCOLN VIP SOCIAL AWARENESS	LINCOLN	971
LVIP BARON GRTH OPPORTUNITIES	LINCOLN	3,772
LVIP BLENDED LC GRTH MNGD VOL	LINCOLN	46
LVIP DIMENSIONAL US CORE EQTY1	LINCOLN	471
LVIP SSGA S&P 500 INDEX	LINCOLN	120,777
LVIP SSGA SMALL-CAP INDEX	LINCOLN	378
LVIP T. ROWE PRICE STRUCTURED	LINCOLN	17,307
MASSMUTUAL SELECT MID CAP GROWTH I FUND	EMP	14,194,644
NB AMT SUSTAINABLE EQ PORT	LINCOLN	525
T. ROWE PRICE INT'L STOCK	LINCOLN	24,916
PIMCO ALL ASSET INSTL	EMP	509,686
PIMCO TOTAL RETURN INSTL	EMP	27,713,406
SCHWAB TARGET 2015	EMP	4,230,790
SCHWAB TARGET 2020	EMP	13,373,280

Children's Hospital Colorado 403(b) Plan

EIN 84-0166760 Plan #002

Schedule H, Line 4(i) – Schedule of Assets
(Held at End of Year) (continued)

Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Identity of Issue, Borrower, Lessor, or Similar Party**	Current Value
Mutual funds (continued):		
SCHWAB TARGET 2025	EMP	$ 21,519,158
SCHWAB TARGET 2030	EMP	22,073,612
SCHWAB TARGET 2035	EMP	26,032,242
SCHWAB TARGET 2040	EMP	33,827,567
SCHWAB TARGET 2045	EMP	43,530,121
SCHWAB TARGET 2050	EMP	45,301,316
SCHWAB TARGET 2055	EMP	39,022,024
SCHWAB TARGET 2060	EMP	1,647,660
VANGUARD EQUITY-INCOME ADM	EMP	30,940,244
Total mutual funds		783,281,731
Fixed annuities:		
*Guaranteed Portfolio Fund	EMP	64,469,760
Lincoln Group Variable Annuity II	LINCOLN	821,968
Total fixed annuities		65,291,728
Pooled investment accounts:		
AMERICAN CENTURY VP CAPITAL APPRECIATION FUND	MOA	61,505
CALVERT VP SRI BALANCED PORTFOLIO	MOA	3,207
DEUTSCHE VARIABLE SERIES I CAPITAL GROWTH VIP	MOA	236,355
FIDELITY VIP ASSET MANAGER PORTFOLIO	MOA	24,126
FIDELITY VIP CONTRAFUND PORTFOLIO	MOA	344,290
FIDELITY VIP EQUITY-INCOME PORTFOLIO	MOA	231,210
MUTUAL OF AMERICA 2030 RETIREMENT FUND	MOA	7,833
MUTUAL OF AMERICA AGGRESSIVE ALLOCATION FUND	MOA	6,839
MUTUAL OF AMERICA ALL AMERICA FUND	MOA	183,251
MUTUAL OF AMERICA BOND FUND	MOA	53,423
MUTUAL OF AMERICA COMPOSITE FUND	MOA	185,064
MUTUAL OF AMERICA EQUITY INDEX FUND	MOA	98,614
MUTUAL OF AMERICA INTEREST ACCUMULATION ACCOUNT	MOA	733,794
MUTUAL OF AMERICA MID-CAP EQUITY INDEX FUND	MOA	31,150
MUTUAL OF AMERICA MID-TERM BOND FUND	MOA	2,574
MUTUAL OF AMERICA MODERATE ALLOCATION FUND	MOA	4,002
MUTUAL OF AMERICA MONEY MARKET FUND	MOA	7,212

Children's Hospital Colorado 403(b) Plan

EIN 84-0166760 Plan #002

Schedule H, Line 4(i) – Schedule of Assets
(Held at End of Year) (continued)

Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Identity of Issue, Borrower, Lessor, or Similar Party**	Current Value
Pooled investment accounts (continued):		
MUTUAL OF AMERICA SMALL CAP GROWTH FUND	MOA	$ 93,919
MUTUAL OF AMERICA SMALL CAP VALUE FUND	MOA	63,181
VANGUARD VIF DIVERSIFIED VALUE PORTFOLIO	MOA	2,842
VANGUARD VIF INTERNATIONAL PORTFOLIO	MOA	21,389
Total pooled investment accounts		2,395,780
Notes receivable from participants:		
*Participant loans: Interest rates ranging from 4.25% to 9.25%, various maturity dates	EMP	9,782,810
		$ 860,752,049

*Represents a party-in-interest
**Mutual of America (MOA), Lincoln Financial Group (LINCOLN), Empower Retirement (EMP)

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SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Children's Hospital Colorado 403(b) Plan

01-JAN-21 to 31-DEC-21

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
1SWGRX			4,034,136.50	4,230,789.97
1SWCRX			12,565,063.81	13,373,279.91
1SWHRX			19,146,278.04	21,519,157.90
1SWDRX			19,395,939.71	22,073,611.66
1SWIRX			22,054,539.93	26,032,241.72
1SWERX			28,849,694.02	33,827,566.84
1SWMRX			34,306,392.00	43,530,121.21
1SWNRX			35,938,783.71	45,301,315.85
1SWORX			32,681,143.83	39,022,024.19
1SWPRX			1,649,498.54	1,647,659.72
1AF-EPG			49,001,509.46	53,942,874.85
1FSPSX			16,226,366.29	19,166,888.95
1GICIX			2,744,740.02	2,947,538.63
1ODVIX			9,098,274.52	10,038,184.98
1IARIX			10,959,417.19	12,682,543.53
1PSVIX			0.00	0.03
1FSSNX			13,345,487.90	17,565,822.26
1FSMLX			17,409,262.82	16,378,997.28
1JSVUX			5,456,670.94	6,007,493.92
1AVUAX			15,899,597.84	18,640,501.83
1FSMDX			47,679,891.00	65,364,385.37
1MEFZX			12,889,963.52	14,194,644.04
1FXAIX			74,148,428.03	116,665,852.61
1FLCNX			26,727,109.59	47,359,104.04
1VEIRX			28,052,044.60	30,940,243.87
1AF-BAL			13,415,201.30	16,970,721.70
1PAAIX			484,012.11	509,685.72
1LSIZX1			4,532,998.38	4,517,884.45
1FXNAX			50,573,077.42	50,793,398.19
1PTTRX			28,432,397.24	27,713,406.21
1KGPF		1.550	57,494,960.63	64,324,866.48
			695,192,880.89	**847,282,807.91**
PARTICIPANT LOANS	VARIOUS	4.250-9.250	9,779,685.45	9,782,810.26
FORFEITURES			52,070.49	144,893.27

Attachment to Form 5500, Schedule H, Part 4, Item I
EIN # 840166760

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Children's Hospital Colorado 403(b) Plan

01-JAN-21 to 31-DEC-21

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE

LEGEND

INVESTMENT OPTION:

1SWGRX	Schwab Target 2015
1SWHRX	Schwab Target 2025
1SWIRX	Schwab Target 2035
1SWMRX	Schwab Target 2045
1SWORX	Schwab Target 2055
1AF-EPG	American Funds EuroPacific Growth Fund A
1GICIX	Goldman Sachs Intl Sm Cap Insights Insl
1IARIX	Invesco Real Estate R5
1FSSNX	Fidelity Small Cap Index
1JSVUX	JPMorgan Small Cap Value R6
1FSMDX	Fidelity Mid Cap Index
1FXAIX	Fidelity 500 Index
1VEIRX	Vanguard Equity-Income Adm
1PAAIX	PIMCO All Asset Instl
1FXNAX	Fidelity US Bond Index
1KGPF	Key Guaranteed Portfolio Fund
1SWCRX	Schwab Target 2020
1SWDRX	Schwab Target 2030
1SWERX	Schwab Target 2040
1SWNRX	Schwab Target 2050
1SWPRX	Schwab Target 2060
1FSPSX	Fidelity International Index
1ODVIX	Invesco Developing Markets R6
1PSVIX	AllianzGI NFJ Small-Cap Value Instl
1FSMLX	Franklin Small Cap Growth R6
1AVUAX	American Century Mid Cap Value I
1MEFZX	MassMutual Mid Cap Growth I
1FLCNX	Fidelity Contrafund K6
1AF-BAL	American Funds Amer Balanced A
1LSIZX1	Columbia Strategic Income Instl
1PTTRX	PIMCO Total Return Instl

COST OF ASSETS: The original cost of the assets in each investment option as of the last day of the plan year
CURRENT VALUE: The value of all assets in each investment option as of the last day of the plan year