

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
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Part I	Annual Report Identification Information
For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
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 <u>MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>002</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>04/01/1987</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>002</u>	1c Effective date of plan <u>04/01/1987</u>	
1b Three-digit plan number (PN) ▶	<u>002</u>				
1c Effective date of plan <u>04/01/1987</u>					
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>MARY FREE BED REHABILITATION HOSPITAL</u> <u>235 WEALTHY SE</u> <u>GRAND RAPIDS, MI 49503-5299</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>38-1359265</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>616-840-8361</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>38-1359265</u>	2c Plan Sponsor's telephone number <u>616-840-8361</u>	2d Business code (see instructions) <u>622000</u>	
2b Employer Identification Number (EIN) <u>38-1359265</u>					
2c Plan Sponsor's telephone number <u>616-840-8361</u>					
2d Business code (see instructions) <u>622000</u>					

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/06/2022	KAREN POWELL
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/06/2022	DAWN BOOMERS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2021)
v. 210624

3a Plan administrator's name and address ☒ Same as Plan Sponsor		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name		4b EIN 4d PN	
5 Total number of participants at the beginning of the plan year		5	2874
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)	1951
a(2) Total number of active participants at the end of the plan year		6a(2)	2136
b Retired or separated participants receiving benefits.....		6b	44
c Other retired or separated participants entitled to future benefits		6c	1171
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	3351
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	2
f Total. Add lines 6d and 6e		6f	3353
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g	3226
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		6h	98
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 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) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor		9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)			
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>6</u> A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☒ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)	

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021		
A Name of plan MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN	B Three-digit plan number (PN) ▶ 002	
C Plan sponsor's name as shown on line 2a of Form 5500 MARY FREE BED REHABILITATION HOSPITAL	D Employer Identification Number (EIN) 38-1359265	

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.
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1 Coverage Information:

(a) Name of insurance carrier
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	707047	3	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.
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(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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
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(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

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(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	39854
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	10425

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. Specify nature of costs ▶	6d	

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

b	Balance at the end of the previous year	7b	38701
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c	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits.....	7c(2)		
	(3) Interest credited during the year.....	7c(3)	1161	
	(4) Transferred from separate account.....	7c(4)		
	(5) Other (specify below)	7c(5)		
	▶			

(6) Total additions	7c(6)	1161
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d	Total of balance and additions (add lines 7b and 7c(6))	7d	39862
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e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier.....	7e(2)	8	
	(3) Transferred to separate account.....	7e(3)		
	(4) Other (specify below)	7e(4)		
	▶			

(5) Total deductions	7e(5)	8
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f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	39854
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Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ 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
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021	
A Name of plan MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 MARY FREE BED REHABILITATION HOSPITAL	D Employer Identification Number (EIN) 38-1359265

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.
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1 Coverage Information:

(a) Name of insurance carrier
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	075746	5	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
0	0

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	

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(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	90671
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	561952

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)****a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☒ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year**7b**

88044

c Additions: (1) Contributions deposited during the year**7c(1)**

(2) Dividends and credits.....

7c(2)

(3) Interest credited during the year.....

7c(3)

2640

(4) Transferred from separate account.....

7c(4)

(5) Other (specify below)

7c(5)

▶

(6) Total additions

7c(6)

2640

d Total of balance and additions (add lines **7b** and **7c(6)**)**7d**

90684

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

(2) Administration charge made by carrier.....

7e(2)

13

(3) Transferred to separate account.....

7e(3)

(4) Other (specify below)

7e(4)

▶

(5) Total deductions

7e(5)

13

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)**7f**

90671

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ 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
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021		
A Name of plan MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 MARY FREE BED REHABILITATION HOSPITAL	D Employer Identification Number (EIN) 38-1359265	

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.
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1 Coverage Information:

(a) Name of insurance carrier
THE 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	CR21475	2	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 1687	(b) Total amount of fees paid 0
--	------------------------------------

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
LINCOLN FINANCIAL ADVISORS
PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1687			4

(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

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	(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** 510211**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 VARIABLE ANNUITY W/GUAR**b** Balance at the end of the previous year **7b** 492981**c** Additions: (1) Contributions deposited during the year **7c(1)**
(2) Dividends and credits..... **7c(2)**
(3) Interest credited during the year..... **7c(3)** 17255
(4) Transferred from separate account..... **7c(4)**
(5) Other (specify below)..... **7c(5)**
▶(6) Total additions **7c(6)** 17255**d** Total of balance and additions (add lines **7b** and **7c(6)**) **7d** 510236**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
(2) Administration charge made by carrier..... **7e(2)** 25
(3) Transferred to separate account..... **7e(3)**
(4) Other (specify below)..... **7e(4)**
▶(5) Total deductions **7e(5)** 25**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 510211

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ 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
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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)	002
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
MARY FREE BED REHABILITATION HOSPITAL 38-1359265		

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.
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1 Coverage Information:

(a) Name of insurance carrier

THE 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	CR34160	18	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
2499	0

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

LINCOLN FINANCIAL ADVISORS PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2499			8

(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** 237066**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 VARIABLE ANNUITY W/GUAR**b** Balance at the end of the previous year **7b** 233961**c** Additions: (1) Contributions deposited during the year **7c(1)**
(2) Dividends and credits..... **7c(2)**
(3) Interest credited during the year..... **7c(3)** 8095
(4) Transferred from separate account..... **7c(4)**
(5) Other (specify below)..... **7c(5)**(6) Total additions **7c(6)** 8095**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 242056**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 4940
(2) Administration charge made by carrier..... **7e(2)** 50
(3) Transferred to separate account..... **7e(3)**
(4) Other (specify below)..... **7e(4)**(5) Total deductions **7e(5)** 4990**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 237066

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ 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
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021	
A Name of plan MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN	B Three-digit plan number (PN) ► 002
C Plan sponsor's name as shown on line 2a of Form 5500 MARY FREE BED REHABILITATION HOSPITAL	D Employer Identification Number (EIN) 38-1359265

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.
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1 Coverage Information:

(a) Name of insurance carrier
THE 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	GP01015	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 4348	(b) Total amount of fees paid 0
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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
LINCOLN FINANCIAL ADVISORS
PO BOX 2239
FORT WAYNE, IN 46801-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4348			4

(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** 833299**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 VARIABLE ANNUITY W/GUAR**b** Balance at the end of the previous year **7b** 904346**c** Additions: (1) Contributions deposited during the year **7c(1)**
(2) Dividends and credits..... **7c(2)**
(3) Interest credited during the year..... **7c(3)** 30487
(4) Transferred from separate account..... **7c(4)** 53520
(5) Other (specify below) **7c(5)**(6) Total additions **7c(6)** 84007**d** Total of balance and additions (add lines **7b** and **7c(6)**) **7d** 988353**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 150511
(2) Administration charge made by carrier..... **7e(2)** 194
(3) Transferred to separate account..... **7e(3)** 520
(4) Other (specify below) **7e(4)** 3828

▶ MAY INCLUDE LOAN ISSUED, FORFEITURE

(5) Total deductions **7e(5)** 155053**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f** 833300

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ 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
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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)	002
MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
MARY FREE BED REHABILITATION HOSPITAL	38-1359265	

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.
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1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	1095023	19	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
250	0

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
1095 AVENUE OF THE AMERICAS
NEW YORK, NY 10036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
250			

(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	84950
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	493700

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. Specify nature of costs ▶	6d	

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

b	Balance at the end of the previous year	7b	82515
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c	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits.....	7c(2)		
	(3) Interest credited during the year.....	7c(3)	2476	
	(4) Transferred from separate account.....	7c(4)		
	(5) Other (specify below)	7c(5)		

▶

(6) Total additions	7c(6)	2476
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d	Total of balance and additions (add lines 7b and 7c(6))	7d	84991
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e Deductions:

	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1	
	(2) Administration charge made by carrier.....	7e(2)	40	
	(3) Transferred to separate account.....	7e(3)		
	(4) Other (specify below)	7e(4)		

▶

(5) Total deductions	7e(5)	41
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f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	84950
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Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.		OMB No. 1210-0110
			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 MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 MARY FREE BED REHABILITATION HOSPITAL	D Employer Identification Number (EIN) 38-1359265	

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 EQUITABLE FINANCIAL LIFE INS COMPAN 13-5570651
--

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

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

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

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

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

GREAT-WEST LIFE & ANNUITY INSURANCE

84-0467907

(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?
65 64	CONTRACT ADMINISTRATOR	301334	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

FIDELITY INVESTMENTS INSTITUTIONAL

04-2647786

(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 65	RECORDKEEPER	975	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

METROPOLITAN LIFE INSURANCE COMPANY

PO BOX 10356
DES MOINES, IA 50306

13-5581829

(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	RECORDKEEPER	40	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2021 This Form is Open to Public Inspection.
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For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan <u>MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN</u>	B Three-digit plan number (PN)	<u>002</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>MARY FREE BED REHABILITATION HOSPITAL</u>	D Employer Identification Number (EIN) <u>38-1359265</u>	

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

a Name of MTIA, CCT, PSA, or 103-12 IE: POOLED SEPARATE ACCOUNT 48

b Name of sponsor of entity listed in (a): EQUITABLE FINANCIAL LIFE INSURANCE COMPANY

c EIN-PN <u>13-5570651-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>572377</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

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

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
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For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>		
A Name of plan <u>MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN</u>	B Three-digit plan number (PN) ►	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MARY FREE BED REHABILITATION HOSPITAL</u>	D Employer Identification Number (EIN) <u>38-1359265</u>	

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash.....	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1773638	2587905
(2) Participant contributions.....	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	552565	604148
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	475608	572377
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	108724187	129313132
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	1840549	1796051
(15) Other.....	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities.....	1d(1)	
(2)	Employer real property.....	1d(2)	
e	Buildings and other property used in plan operation	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	113366547 134873613
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	
i	Acquisition indebtedness.....	1i	
j	Other liabilities.....	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	113366547 134873613

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.

		(a) Amount	(b) Total
Income			
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	5985614
	(B) Participants	2a(1)(B)	7994692
	(C) Others (including rollovers).....	2a(1)(C)	2515076
(2)	Noncash contributions.....	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	16495382
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	
	(C) Corporate debt instruments	2b(1)(C)	
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans.....	2b(1)(E)	37709
	(F) Other	2b(1)(F)	62112
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	99821
(2)	Dividends: (A) Preferred stock.....	2b(2)(A)	
	(B) Common stock	2b(2)(B)	
	(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	5852055
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	5852055
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	
	(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		173462
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		8972446
c Other income.....	2c		24793
d Total income. Add all income amounts in column (b) and enter total.....	2d		31617959
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	9812414	
(2) To insurance carriers for the provision of benefits.....	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		9812414
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		-5170
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees.....	2i(1)		
(2) Contract administrator fees.....	2i(2)		
(3) Investment advisory and management fees.....	2i(3)	12208	
(4) Other.....	2i(4)	291441	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		303649
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		10110893
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d.....	2k		21507066
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan.....	2l(2)		

Part III Accountant's Opinion

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

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

(1) ☐ Unmodified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

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

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

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

(1) Name: HUNGERFORD NICHOLS

(2) EIN: 38-2184825

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

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

Part IV Compliance Questions

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

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....

	Yes	No	Amount
4a		X	

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

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

A Name of plan <u>MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN</u>	B Three-digit plan number (PN) ▶ <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MARY FREE BED REHABILITATION HOSPITAL</u>	D Employer Identification Number (EIN) <u>38-1359265</u>

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
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): <u>84-1455663</u>	
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

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

Schedule R (Form 5500) 2021
v. 201209

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 _____

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

FINANCIAL STATEMENTS

For the years ended
December 31, 2021 and 2020

TABLE OF CONTENTS

INDEPENDENT AUDITOR’S REPORT	1
FINANCIAL STATEMENTS	
Statements of Assets Available for Benefits	6
Statements of Changes in Assets Available for Benefits	7
Notes to Financial Statements	8
SUPPLEMENTAL SCHEDULE	
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)	18



INDEPENDENT AUDITOR'S REPORT

September 26, 2022

To the Plan Administrator of the
Mary Free Bed Rehabilitation Hospital 403(b) Plan
Grand Rapids, Michigan

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

We have performed an audit of the financial statements of Mary Free Bed Rehabilitation Hospital 403(b) 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 assets available for benefits as of December 31, 2021, and the related statement of changes in assets available for benefits for the year then ended, and the related notes to the financial statements (2021 Financial Statements).

Management, having determined it is permissible in the circumstances, has elected to have the audit of the 2021 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 and for the year ended December 31, 2021 stating that the certified investment information, as described in Note E 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 2021 Financial Statements of Mary Free Bed Rehabilitation Hospital 403(b) Plan. Because of the significance of the matters described in the Basis for Disclaimer of Opinion for 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.

Basis for Disclaimer of Opinion on the 2021 Financial Statements

Mary Free Bed Rehabilitation Hospital 403(b) 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 accompanying financial statements may have been affected by these conditions.

Further, as described in Note B to the financial statements, the Mary Free Bed Rehabilitation Hospital 403(b) Plan has excluded from investments in the accompanying statement of 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 have also been excluded in the accompanying statement of changes in assets available for benefits. The amount of these excluded annuity contracts and custodial accounts and the related income and distributions are not reasonably 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 accompanying financial statements.

Responsibilities of Management for the 2021 Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, 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 Mary Free Bed Rehabilitation Hospital 403(b) Plan's ability to continue as a going concern for one year after the date 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 Mary Free Bed Rehabilitation Hospital 403(b) 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 matters 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 audit evidence to provide a basis for an audit opinion on these financial statements.

We are required to be independent of Mary Free Bed Rehabilitation Hospital 403(b) Plan, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit.

Other Matters

Supplemental Schedule Required by ERISA

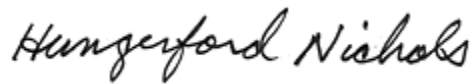
The supplemental schedule of Assets (Held at End of Year) is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. Because of the significance of the matters described in the Basis for Disclaimer of Opinion for the 2021 Financial Statements section of our report, it is inappropriate to, and we do not express an opinion on this supplemental schedule.

Auditor's Report on the 2020 Financial Statements

We were engaged to audit the 2020 financial statements of Mary Free Bed Rehabilitation Hospital 403(b) Plan. 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 information certified by a qualified institution. Further, Mary Free Bed Rehabilitation Hospital 403(b) 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 accompanying financial statements may have been affected by these conditions.

Mary Free Bed Rehabilitation Hospital 403(b) Plan has excluded from the 2020 financial statements 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 have also been excluded from the 2020 financial statements. 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 2020 financial statements.

In our report dated October 8, 2021, we indicated that because of the significance of the information that we did not audit, we were not able 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.

A handwritten signature in black ink that reads "Hungerford Nichols". The signature is written in a cursive, flowing style.

Certified Public Accountants
Grand Rapids, Michigan

FINANCIAL STATEMENTS

STATEMENTS OF ASSETS AVAILABLE FOR BENEFITS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

	2021	2020
Assets		
Investments at fair value:		
Mutual funds	\$ 128,819,432	\$ 107,965,592
Pooled separate accounts	1,066,077	1,234,203
Investments at contract value:		
Insurance company unallocated contracts	1,796,051	1,840,549
Total investments	131,681,560	111,040,344
Receivables:		
Employer contribution receivable	2,587,905	1,773,638
Notes receivable from participants	604,148	552,565
Total receivables	3,192,053	2,326,203
Assets Available for Benefits	\$ 134,873,613	\$ 113,366,547

STATEMENTS OF CHANGES IN ASSETS AVAILABLE FOR BENEFITS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

For the years ended December 31, 2021 and 2020

	2021	2020
Additions to Assets Attributed to:		
Investment income:		
Interest and dividends	\$ 5,914,167	\$ 3,399,415
Net appreciation in fair value of investments	9,145,908	12,405,660
Other Income	24,793	17,551
Total investment income	15,084,868	15,822,626
Interest income on notes receivable from participants	37,709	41,927
Contributions:		
Employer	5,985,614	4,512,593
Participant	7,994,692	6,705,829
Rollover	2,515,076	1,753,456
Total contributions	16,495,382	12,971,878
Total Additions	31,617,959	28,836,431
Deductions from Assets Attributed to:		
Benefits paid to participants	9,807,244	9,113,665
Administrative expenses	303,649	227,835
Total Deductions	10,110,893	9,341,500
Net Increase	21,507,066	19,494,931
Assets Available for Benefits:		
Beginning of year	113,366,547	93,871,616
End of year	\$ 134,873,613	\$113,366,547

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note A – Description of Plan

The following description of Mary Free Bed Rehabilitation Hospital 403(b) Plan (Plan) provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution 403(b) plan covering substantially all employees of Mary Free Bed Rehabilitation Hospital (Organization), the Plan's sponsor. Eligible employees can become participants in the Plan and become eligible to receive employer contributions on the employee's date of employment. Any person who becomes an employee as a result of an acquisition will receive credit for service with the prior employer during the plan year of the acquisition. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Participants may elect to make pre-tax contributions or after-tax Roth contributions to the Plan through payroll deductions from each participant's compensation, as defined, subject to statutory limitations. Upon satisfying eligibility requirements, employees are automatically enrolled in the Plan at a rate of 3% of eligible compensation, unless they elect otherwise. Participants that meet certain criteria are eligible to make catch-up contributions to the Plan. The Plan also allows participants to transfer funds from other qualified plans into the Plan.

The Organization may elect to make discretionary matching contributions. Matching contributions are made based on pay deferral contributions made on behalf of each participant who has completed one year of service with at least 1,000 hours and is employed on the last day of the plan year. The Organization made matching contributions of 50% of employee deferrals up to 6% deferred by each participant for the years ended December 31, 2021 and 2020.

The Organization also makes a non-elective contribution to the Plan that is based upon each participant's compensation and years of benefit service. For the plan years ended December 31, 2021 and 2020, the calculation was as follows:

<u>Participant's Years of Benefit Service</u>	<u>Percentage of Participant's Compensation</u>
Less than 5.0	2%
5.0 – 9.9	3%
10.0 – 14.9	4%
15.0 or more	5%

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note A – Description of Plan (Continued)

Contributions (Continued)

Participants working as physicians as part of the Mary Free Bed Medical Group will receive a non-elective contribution of 5% of compensation, regardless of their years of service. In order to receive the employer non-elective contribution, a participant must be employed on the last day of the plan year and have at least 1,000 hours of service during that plan year.

In addition, eligible participants may receive a “transition” contribution in an amount equal to 3% of the participant’s compensation, based on eligibility conditions contained in the plan document.

Plan Operations

The Organization has appointed Great-West Trust Company, Lincoln National Life Insurance Company, Fidelity Management Trust Company, Metropolitan Life Insurance Company, and Equitable Financial Life Insurance Company (Certifying Entities) to serve as custodians of the Plan’s assets. These entities are responsible for holding investment assets of the Plan, executing investment transactions and making distributions to participants. The Organization acts as plan administrator. The plan administrator interprets and communicates the provisions of the Plan and ensures that all government and participant reporting requirements are fulfilled. The Plan’s fiduciary committee is responsible for oversight of the Plan, determines the appropriateness of the Plan’s investment strategy, and monitors investment performance.

Participant Accounts

Individual accounts are maintained for each participant, with benefits limited to the amount contributed to the participant’s account plus or minus any allocation of income, expenses, gains, or losses. Allocations to participant accounts are based on compensation or account balances, as specified by the plan document. The benefit to which a participant is entitled is the benefit that can be provided from the participant’s vested account.

The Plan allows a participant to self-direct investment transactions associated with separate investment fund options made available by the employer for this purpose.

Vesting

Participants are immediately 100% vested in their deferral and rollover contribution accounts. Company contribution accounts are fully vested upon three years of service, as defined by the Plan. A participant also becomes fully vested if the participant dies or becomes disabled while employed or upon attainment of normal retirement age.

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note A – Description of Plan (Continued)

Loans to Participants

Under certain conditions, a participant may obtain a loan from the Plan. A participant may borrow a minimum of \$1,000 up to a maximum of the lesser of \$50,000, reduced by the participant's highest outstanding loan balance during the 12 month period before the loan is made, or one half of the participant's interest in the Plan. The loan will bear interest at a reasonable rate, be adequately secured, and not exceed a period of five years (unless secured by a principal residence). Principal and interest repayments are made through payroll deductions.

Payment of Benefits

On termination of service, a participant may elect to receive a lump sum payment equal to the vested interest in his or her account or installment payments. In-service withdrawals are also permitted after having attained age 59½ or in cases of financial hardship.

Costs and Expenses

Certain transaction fees and other administrative expenses are paid by the Plan and are based on reasonable and customary rates. Certain other costs and expenses incurred in connection with the operation of the Plan are borne by the Organization.

Forfeited Accounts

Forfeited balances may be used to pay reasonable administrative expenses of the Plan or to reduce employer contributions. The balance in the Plan's forfeiture account as of December 31, 2021 and 2020 was \$336,021 and \$313,434, respectively. Forfeitures of \$361,080 and \$287,763 were used to reduce employer contributions for the years ended December 31, 2021 and 2020, respectively.

Note B – Summary of Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared using the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Accordingly, actual results could differ from those estimates.

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note B – Summary of Accounting Policies (Continued)

Investment Valuation and Income Recognition

Investments are reported in the Plan's financial statements at fair value, except for fully benefit-responsive investment contracts, which are reported at contract value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note C for discussion of fair value measurements.

Contract value is the relevant measurement for assets invested in fully-benefit responsive investment contracts because contract value is the amount participants normally would receive if they were initiate permitted transactions under the terms of the Plan.

Income from interest is recorded as it is earned. Dividends are recorded on the ex-dividend date. Purchases and sales of securities are recorded on a trade date basis. Net appreciation or depreciation of investments is determined using the value at the beginning of the year or purchase price if acquired since that date. Management fees and operating expenses charged to the Plan for investments in mutual funds and pooled separate accounts are deducted from income earned on a daily basis and are not separately reflected. Consequently, management fees and operating expenses are reflected as a reduction of investment return for such investments.

Excluded Contracts

The plan administrator has elected to exclude certain contracts and accounts from plan assets in accordance with DOL FAB 2009-02 due to the following:

- the contract or account was issued to a current or former employee before January 1, 2009
- the employer ceased to have any obligation to make contributions (including employee salary reduction contributions), and in fact, stopped making contributions to the contract or account before January 1, 2009
- all the rights under the contract or account are legally enforceable against the insurer by the individual owner of the contract or account without any involvement by the employer
- the individual owner of the contract should be fully vested in the contract or account

Because the plan administrator has elected to exclude certain contracts in accordance with DOL FAB 2009 02, the excluded contracts are not in accordance with GAAP and, accordingly, it is not intended that these financial statements be presented in accordance with GAAP.

Notes Receivable from Participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest is recorded on the accrual basis. Related fees are charged directly to the participant's account and are included in administrative expenses when incurred. Delinquent notes receivable from participants are recorded as a distribution based upon the terms of the plan document; therefore, an allowance for credit losses is not considered necessary at December 31, 2021 and 2020.

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note B – Summary of Accounting Policies (Continued)

Benefits

Benefits are recorded when paid.

Subsequent Events

Management evaluates events occurring subsequent to the date of the financial statements in determining the accounting for and disclosure of transactions and events that affect the financial statements. Subsequent events have been evaluated through September 26, 2022, which is the date the financial statements were available to be issued.

Note C – Fair Value Measurements

The Plan's investments, except those that are required to be reported at contract value, are reported at fair value in the accompanying statements of assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The fair value measurement accounting literature establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described as follows:

Level 1 – inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the Plan has the ability to access.

Level 2 – inputs to the valuation methodology include:

- quoted prices for similar assets and liabilities in active markets
- quoted prices for identical or similar assets and liabilities in markets that are not active
- other inputs that are observable or can be corroborated by observable market data
- inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note C – Fair Value Measurements (Continued)

Level 3 – inputs are generally unobservable and significant to the fair value measurement. Such inputs typically reflect management's estimates of assumptions that market participants would use in pricing the asset or liability, including certain pricing models, discounted cash flow methodologies and similar techniques that use significant unobservable inputs.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for investments measured at fair value. There have been no changes in the methodologies used at December 31, 2021 and 2020.

Mutual funds: Valued based on quoted net asset values (NAV) of the shares held by the Plan on the last business day of the plan year.

Pooled separate accounts: Valued at NAV based on the closing price for underlying securities, reported on the active market on which underlying securities are traded or based on quoted prices of similar assets. The NAV of each of the separate accounts is reported daily by the fund managers as based on recent transaction prices, and represents the price at which the Plan would be able to initiate a transaction. The pooled separate accounts held by the Plan provide for daily redemptions by the Plan at reported NAV with no advance notice requirement, and have no unfunded commitments.

The following tables set forth by level, within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2021 and 2020:

	Level 1	Level 2	Level 3	Total
<u>December 31, 2021</u>				
Mutual funds	\$ 128,819,432	\$ -	\$ -	\$ 128,819,432
Pooled separate accounts	-	1,066,077	-	1,066,077
	<u>\$ 128,819,432</u>	<u>\$ 1,066,077</u>	<u>\$ -</u>	<u>\$ 129,885,509</u>
<u>December 31, 2020</u>				
Mutual funds	\$ 107,965,592	\$ -	\$ -	\$ 107,965,592
Pooled separate accounts	-	1,234,203	-	1,234,203
	<u>\$ 107,965,592</u>	<u>\$ 1,234,203</u>	<u>\$ -</u>	<u>\$ 109,199,795</u>

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note D – Investment Contracts with Insurance Companies

Plan assets include benefit-responsive group annuity fixed income contracts issued by the Lincoln National Life Insurance Company, Metropolitan Life Insurance Company and Equitable Financial Life Insurance Company. The methodology for calculating the interest crediting rate is defined in the terms of the contracts. Under terms of the existing contracts, the crediting rate is generally reset on a quarterly basis and will never be less than 1.75%.

As described above, because the fixed income contracts are fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the assets available for benefits attributable to the contract. Contract value, as reported to the Plan by the issuers, represents contributions made under the contract, plus earnings at guaranteed crediting rates, less participant withdrawals and fees. There are not any events that could limit the ability of the Plan to transact at contract value paid within twelve months. There are not any events that allow the issuer to terminate the contract which would require the plan sponsor to settle at an amount different than contract value paid within twelve months. Participants may ordinarily direct permitted withdrawal or transfer of all or a portion of their investment at contract value within reasonable timeframes.

By definition, the fixed income contracts are insurance contracts. As a result, the Plan may transact or terminate the contracts according to the terms defined in the contracts at any time.

Note E – Information Certified by Certifying Entities

All investment information disclosed in the accompanying financial statements and supplemental schedule, including investments held and notes receivable from plan participants at December 31, 2021 and 2020, and net appreciation in fair value of investments, interest, and dividends for the years ended December 31, 2021 and 2020, were obtained or derived from information supplied to the plan administrator and certified as complete and accurate by the Certifying Entities.

Note F – Risks and Uncertainties

Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amount reported in the statements of assets available for benefits.

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note G – Party-In-Interest Transactions

Plan investments include investments managed by affiliates of the Plan custodians and insurance contract holders. As defined by the Plan, these transactions qualify as party-in-interest transactions.

Fees paid by the Plan to parties-in-interest for services rendered to the Plan were \$303,649 and \$227,835 for the years ended December 31, 2021 and 2020, respectively. Such fees were based on reasonable and customary rates.

Note H – Plan Termination

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

Note I – Tax Status

The volume submitter plan used by the Plan has been designed to qualify under Section 403(b) of the Internal Revenue Code (IRC). The terms of the Plan have been prepared to conform to the sample language provided by the Internal Revenue Service (IRS). The Plan is required to operate in conformity with the IRC to maintain the tax exempt status for plan participants under Section 403(b). The Plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC. Therefore, no provision for income taxes has been included in the Plan's financial statements.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2021, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax period in progress. The plan administrator believes it is no longer subject to income tax examinations for years prior to 2018.

NOTES TO FINANCIAL STATEMENTS

MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN

December 31, 2021 and 2020

Note J – Coronavirus Aid Relief and Economic Security Act

In response to the pandemic, on March 27, 2020 the Coronavirus Aid, Relief and Economic Security Act ("CARES Act") was enacted to provide economic relief to businesses and individuals impacted by the pandemic. Provisions of the CARES Act included increasing the amount that participants may borrow from their account up to the lesser of \$100,000 or 100% of the vested account balance until 180 days after the Act's enactment date, and also allowed participants the option to delay loan payments due between March 27, 2020 and December 31, 2020 until January 1, 2021.

The CARES Act allowed impacted Plan participants to request and receive up to \$100,000 of their vested account balance prior to December 31, 2020. The benefits paid will be included in the participant's taxable income over three years, unless the participant elects to have them taxed in the year of distribution. These benefit payments will not be subject to the 10% penalty for early withdrawal. Repayment to the Plan is permitted within three years of the distribution.

SUPPLEMENTAL SCHEDULE

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN**

December 31, 2021

EIN 38-1359265

PN 002

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost **	(e) Current Value
	<u>Equitable Financial:</u>			
*	Equitable Investment Management	EQ/COM Stock Index	\$	434,542
		1290 VT GAMCO Small Co Val		49,543
		Guaranteed Interest Account		130,525
		EQ/Balanced Strategy		44,615
		Multimanager Aggressive Equity		19,666
		EQ/Lg Cap Val Managed Vol		21,079
		EQ/AB Small Cap Growth		74
		EQ/International Equity Index		43
		EQ/Int Core Managed Vol		34
		1290 VT Small Cap Value		46
		Target 2035 Allocation		2,735

* Indicates party-in-interest

** Not required for participant directed accounts

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**MARY FREE BED REHABILITATION HOSPITAL 403(b) PLAN**

December 31, 2021

EIN 38-1359265

PN 002

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost **	(e) Current Value
<u>Great-West Trust Company:</u>				
	Vanguard	Vanguard Federal Money Market		\$ 362,815
	* Participant Loans	4.25% - 6.50%		604,148
	See attached schedules for additional investments and participant loans held by others.			130,615,843

* Indicates party-in-interest

** Not required for participant directed accounts

INV OPTION CODE	INV OPTION NAME	INV OPTION TYPE	SUGGESTED FASB ASC 820 CATEGORY CODE	TOTAL VALUE
1ABSAX	AMERICAN BEACON SMALL CP VAL A	Mutual Funds	1	449,323.21
1RERGX	AMERICAN FUNDS EUROPACIFIC GR R6	Mutual Funds	1	1,788,841.90
1FTIAX	FEDERATED HERMES SHORT-TERM INCOME A	Mutual Funds	1	494,723.91
1FXAIX	FIDELITY 500 INDEX	Mutual Funds	1	6,262,884.57
1FSMAX	FIDELITY EXTENDED MARKET INDEX	Mutual Funds	1	1,962,137.16
1JDVWX	JHANCOCK DISCIPLINED VALUE R6	Mutual Funds	1	815,712.94
1JMVYX	JPMORGAN MID CAP VALUE R6	Mutual Funds	1	497,050.07
1MLAIX	MAINSTAY WINSLOW LARGE CAP GROWTH I	Mutual Funds	1	1,816,887.23
1MWTNX	METROPOLITAN WEST TOTAL RE BD ADMIN CL	Mutual Funds	1	2,958,475.58
1OAKIX	OAKMARK INTERNATIONAL INVESTOR	Mutual Funds	1	329,096.26
1OARIX	OAKMARK INTERNATIONAL SERVICE	Mutual Funds	1	0.00
1PONAX	PIMCO INCOME A	Mutual Funds	1	1,127,184.14
1TFRRX	T ROWE PRICE TARGET 2005 I	Mutual Funds	1	8,719.06
1TORFX	T ROWE PRICE TARGET 2010 I	Mutual Funds	1	303,042.78
1TTRTX	T ROWE PRICE TARGET 2015 I	Mutual Funds	1	2,176,334.28
1TTURX	T ROWE PRICE TARGET 2020 I	Mutual Funds	1	6,901,015.21
1TRVVX	T ROWE PRICE TARGET 2025 I	Mutual Funds	1	9,913,372.32
1TWRRX	T ROWE PRICE TARGET 2030 I	Mutual Funds	1	16,949,009.15
1TPGPX	T ROWE PRICE TARGET 2035 I	Mutual Funds	1	12,536,305.41
1TRXRX	T ROWE PRICE TARGET 2040 I	Mutual Funds	1	9,909,719.84
1TRFWX	T ROWE PRICE TARGET 2045 I	Mutual Funds	1	10,575,402.93
1TOORX	T ROWE PRICE TARGET 2050 I	Mutual Funds	1	13,778,755.66
1TRPPX	T ROWE PRICE TARGET 2055 I	Mutual Funds	1	8,166,098.52
1TTOIX	T ROWE PRICE TARGET 2060 I	Mutual Funds	1	3,279,449.01
1PMEGX	T. ROWE PRICE INSTL MID-CAP EQUITY GR	Mutual Funds	1	2,037,309.84
1TQAIX	T. ROWE PRICE QM US SMALL-CAP GR EQ I	Mutual Funds	1	1,002,568.35
1VMFXX	VANGUARD FEDERAL MONEY MARKET INV	Mutual Funds	1	873,299.14
1VAIPX	VANGUARD INFLATION-PROTECTED SECS ADM	Mutual Funds	1	1,065,310.13
1VWILX	VANGUARD INTERNATIONAL GROWTH ADM	Mutual Funds	1	1,974,810.06
FASB ASC 820 CATEGORY CODE 1 SUB-TOTAL				119,952,838.66
PLAN TOTAL				119,952,838.66 **

** Participant Loans - reported separately as notes receivable from participants and not included in this total. Please refer to the Loan Summary for details.

** Forfeitures / Unallocated Plan Assets - For fund types and balances, please refer to the Forfeiture / Asset Holding Account report.

NOTE: The investments reported above include any investment in the plan recordkept by the provider that had a value as of the report begin date, a value as of the report end date or any activity (e.g., purchases or sales) during the reporting period. The values reported above are the values used for plan and participant reporting purposes. These values do not factor in liquidation restrictions such as redemption fees, market timing fees or contract termination fees. Please refer to each investment's prospectus or contract for more information on any potential liquidation restrictions.



Participant Summary by Investment Report
For Plan: Mary Free Bed Orthotics

Date Range Requested: 01/01/2021 - 12/31/2021 Data Extracted: 02/14/2022

This information is based on records maintained by The Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York, herein separately and collectively referred to as ("Lincoln") and is provided on a Cash basis. Any adjustments made to the account after the plan year end into a prior year may affect activity shown on this report.

Plan Information

Vendor System Plan ID		Plan Name	Plan Number	Employer Identification Number (EIN)	Plan Type	Full Service	Plan Sponsor / Employer Name	Plan Sponsor / Employer Address	Plan Sponsor/ Plan Admin Phone
Lincoln - APS	CR21475	MARY FREE BED ORTHOTICS AND PROSTHETICS	000	38-1359265	403(b)	N	MARY FREE BED ORTHOTICS AND PROSTHETICS	ATTN KAREN POWELL, 235 WEALTHY SE, GRAND RAPIDS, MI 49503-5299	
Lincoln - APS	CR34160	MARY FREE BED HOSPITAL RETIREMENT PLAN	000	38-1359265	403(b)	Y	MARY FREE BED HOSPITAL RETIREMENT PLAN	235 WEALTHY ST SE, GRAND RAPIDS, MI 49503-5299	
Lincoln - APS	GP01015	MARY FREE BED HOSPITAL RETIREMENT PLAN	000	38-1359265	403(b)	Y	MARY FREE BED HOSPITAL RETIREMENT PLAN	235 WEALTHY ST SE, GRAND RAPIDS, MI 49503-5299	

Plan Totals by Investments

Investment	Beginning Balance	Contributions	Loan Payments	Investment Earnings	Withdrawals	Transfer	Account Charges	Ending Balance
AB VPS GLOBAL THEMATIC GROWTH	20,927.04	0.00	0.00	4,466.66	0.00	0.00	-20.73	25,372.97
AMERICAN FUNDS GLOBAL GROWTH	5,199.09	0.00	0.00	793.52	0.00	0.00	-5.20	5,987.41
AMERICAN FUNDS GROWTH	398,287.56	0.00	0.00	81,487.34	-8,130.78	-7,905.97	-221.74	463,516.41
AMERICAN FUNDS GROWTH-INCOME	53,465.19	0.00	0.00	12,216.55	0.00	0.00	-36.29	65,645.45
AMERICAN FUNDS INTERNATIONAL	91,907.18	0.00	0.00	-2,274.50	0.00	0.00	-56.40	89,576.28
DELAWARE VIP SMALL CAP VALUE	54,254.38	0.00	775.47	17,793.91	0.00	520.00	-41.15	73,302.61

* Indicates Party-In-Interest



Participant Summary by Investment Report
For Plan: Mary Free Bed Orthotics

Schedule H, Line 4i, Schedule of Assets (Held at Year End)
Mary Free Bed Rehabilitation Hospital 403(b) Plan
December 31, 2021
EIN 38-1359265
PN 002

Date Range Requested: 01/01/2021 - 12/31/2021

Data Extracted: 02/14/2022

This information is based on records maintained by The Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York, herein separately and collectively referred to as ("Lincoln") and is provided on a Cash basis. Any adjustments made to the account after the plan year end into a prior year may affect activity shown on this report.

FIDELITY VIP CONTRAFUND	129,408.67	0.00	0.00	31,095.74	-14,864.20	-12,475.46	-82.82	133,081.93
FIDELITY VIP GROWTH	105,081.90	0.00	0.00	22,948.67	0.00	0.00	-34.99	127,995.58
* FIXED ACCOUNT	1,631,288.68	0.00	-3,828.07	55,836.20	-155,451.27	52,999.83	-269.11	1,580,576.26
LVIP BARON GROWTH OPPORTUNITIES	68,707.87	0.00	0.00	12,043.44	0.00	0.00	-52.94	80,698.37
LVIP BLACKROCK DIVIDEND VALUE MNGDVLTLTY	44,678.17	0.00	0.00	8,524.31	-5,832.52	-6,068.93	-15.42	41,285.61
LVIP BLENDED LRG CAP GROWTH MNGD VOLTLY	32,756.92	0.00	0.00	9,678.11	0.00	0.00	-23.28	42,411.75
LVIP DELAWARE DIVERSIFIED INCOME SE	5,169.62	0.00	0.00	-118.89	0.00	0.00	-4.28	5,046.45
LVIP DELAWARE MID CAP VALUE FUND	36,008.49	0.00	386.16	10,965.76	0.00	0.00	-36.47	47,323.94
LVIP DELAWARE REIT SERIES	10,815.95	0.00	570.90	4,573.12	0.00	0.00	-9.56	15,950.41
LVIP DELAWARE SMID CAP CORE SERIES	214,107.99	0.00	0.00	46,037.26	-6,741.45	-6,329.22	-101.61	246,972.97
LVIP DELAWARE SOCIAL AWARENESS	120,591.61	0.00	392.79	30,291.94	-597.12	0.00	-66.41	150,612.81
LVIP DELAWARE VALUE SERIES	9,589.07	0.00	574.22	2,043.24	0.00	0.00	-10.08	12,196.45
LVIP DELAWARE WEALTH BUILDER FUND	15,577.71	0.00	0.00	921.52	-6,859.16	-5,958.40	-6.98	3,674.69
LVIP DIMENSIONAL U.S. CORE EQUITY 1	27,982.10	0.00	0.00	7,311.47	-689.27	0.00	-27.84	34,576.46
LVIP JPMORGAN RETIREMENT INCOME FUND	11,725.70	0.00	0.00	561.97	-141.50	0.00	-6.63	12,139.54
LVIP MONDRIAN INTERNATIONAL VALUE	32,570.05	0.00	554.31	3,287.69	0.00	0.00	-18.18	36,393.87



Participant Summary by Investment Report
For Plan: Mary Free Bed Orthotics

Schedule H, Line 4i, Schedule of Assets (Held at Year End)
Mary Free Bed Rehabilitation Hospital 403(b) Plan
December 31, 2021
EIN 38-1359265
PN 002

Date Range Requested: 01/01/2021 - 12/31/2021 Data Extracted: 02/14/2022

This information is based on records maintained by The Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York, herein separately and collectively referred to as ("Lincoln") and is provided on a Cash basis. Any adjustments made to the account after the plan year end into a prior year may affect activity shown on this report.

LVIP SSGA GLBL TACTICAL ALLOCTN MGD VLT	7,931.79	0.00	0.00	885.85	0.00	0.00	-25.00	8,792.64
LVIP SSGA S&P 500 INDEX	110,410.22	0.00	0.00	28,218.76	-7,370.87	-6,431.74	-60.94	124,765.43
LVIP SSGA SMALL-CAP INDEX	10,367.86	0.00	0.00	1,391.00	0.00	0.00	-4.56	11,754.30
LVIP T. ROWE PRICE STRUCTURED MID-CAP	49,306.21	0.00	0.00	5,677.52	-7,609.32	-8,350.11	-12.92	39,011.38
MFS UTILITIES	54,611.95	0.00	574.22	7,046.19	0.00	0.00	-48.47	62,183.89
Grand Total	3,352,728.97	0.00	0.00	403,704.35	-214,287.46	0.00	-1,300.00	3,540,845.86

* Indicates Party-In-Interest

Schedule H, Line 4i, Schedule of Assets (Held at Year End)
Mary Free Bed Rehabilitation Hospital 403(b) Plan
December 31, 2021
EIN 38-1359265
PN 002

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2021

	<u>Fund Name</u>	<u>Share Balance 12/31/2021</u>	<u>Historical Cost</u>	<u>Price</u>	<u>Total Market Value</u>
*	FID FIDELITY FUND	406.234	\$15,949.75	\$79.16	\$32,157.48
*	FID PURITAN	1,557.987	\$31,957.66	\$27.20	\$42,377.25
*	FID SEL CONS STAPLES	79.402	\$7,567.97	\$97.82	\$7,767.10
*	FID GNMA	282.159	\$3,155.66	\$11.58	\$3,267.40
*	FID MAGELLAN	5,269.521	\$52,935.08	\$15.37	\$80,992.54
*	FID CONTRAFUND	13,976.844	\$146,577.71	\$18.76	\$262,205.59
*	FID EQUITY INC	735.181	\$39,122.24	\$70.24	\$51,639.11
*	FID GROWTH COMPANY	23,515.666	\$308,298.03	\$36.47	\$857,616.34
*	FID GROWTH & INC	1,560.080	\$51,268.96	\$51.85	\$80,890.15
*	FID INTERMED BOND	353.111	\$3,721.59	\$11.02	\$3,891.28
*	FID CAPITAL & INCOME	1,306.140	\$12,939.15	\$11.21	\$14,641.83
*	FID SEL BIOTECH	187.799	\$3,959.91	\$19.35	\$3,633.91
*	FID SEL ENERGY	91.281	\$3,180.44	\$35.32	\$3,224.04
*	FID SEL LEISURE	452.376	\$6,437.19	\$17.47	\$7,903.01
*	FID SEL HEALTHCARE	0.000	\$0.00	\$32.31	\$0.00
*	FID SEL UTILITIES	62.514	\$4,678.73	\$105.05	\$6,567.10
*	FID SEL DEFENSE	240.823	\$2,438.78	\$15.85	\$3,817.04
*	FID OTC PORTFOLIO	28,499.609	\$225,520.14	\$19.60	\$558,592.34
*	FID REAL ESTATE INVS	1,321.961	\$45,052.84	\$54.02	\$71,412.33
*	FID BALANCED	8,747.979	\$198,331.35	\$30.37	\$265,676.12
*	FID INTL DISCOVERY	893.298	\$41,153.51	\$52.93	\$47,282.26
*	FID CONVERTIBLE SEC	0.000	\$0.00	\$36.47	\$0.00
*	FID CANADA	112.292	\$5,035.71	\$64.55	\$7,248.45
*	FID TELECOM & UTIL	198.137	\$5,002.03	\$27.95	\$5,537.93
*	FID BLUE CHIP GR	3,789.377	\$293,698.27	\$183.62	\$695,805.40
*	FID ASSET MGR 50%	13,395.011	\$223,062.09	\$22.24	\$297,905.04
*	FID DISCIPLND EQTY	526.139	\$14,361.25	\$65.30	\$34,356.88
*	FID LOW PRICED STK	2,127.611	\$93,597.39	\$53.79	\$114,444.20
*	FID EQ DIV INCOME	757.387	\$18,251.95	\$27.88	\$21,115.95
*	FID ASSET MGR 70%	14,117.126	\$246,723.11	\$28.89	\$407,843.77
*	FID EMERGING MKTS	171.890	\$5,438.78	\$43.65	\$7,503.00
*	FID GROWTH STRAT	33.331	\$895.99	\$63.52	\$2,117.19
*	FID DIVERSIFD INTL	78.636	\$2,685.51	\$48.50	\$3,813.85
*	FID DIVIDEND GR	4,411.040	\$131,052.61	\$36.65	\$161,664.62
*	FID NEW MARKETS INC	4,158.551	\$62,454.48	\$14.24	\$59,217.77
*	FID INTL CAP APPREC	1,737.585	\$40,258.95	\$28.40	\$49,347.41
*	FID MID CAP STOCK	6,155.290	\$199,600.57	\$42.18	\$259,630.13

* Indicates Party-In-Interest

Schedule H, Line 4i, Schedule of Assets (Held at Year End)
Mary Free Bed Rehabilitation Hospital 403(b) Plan
December 31, 2021
EIN 38-1359265
PN 002

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2021

<u>Fund Name</u>	<u>Share Balance 12/31/2021</u>	<u>Historical Cost</u>	<u>Price</u>	<u>Total Market Value</u>
* FID SMALL CAP STOCK	506.727	\$9,258.58	\$19.99	\$10,129.47
* FID ASSET MGR 85%	60.954	\$839.91	\$26.68	\$1,626.25
* FID LATIN AMERICA	184.429	\$5,376.39	\$19.13	\$3,528.13
* FID SEL IT SERVICES	110.492	\$5,906.52	\$82.89	\$9,158.68
* FID FREEDOM 2020	13,832.260	\$214,367.70	\$16.65	\$230,307.13
* FID FREEDOM 2030	14,138.989	\$219,049.83	\$19.34	\$273,448.05
* FID SM CAP DISCOVERY	556.592	\$14,272.24	\$30.65	\$17,059.54
* FID SEL COMM SERV	62.956	\$4,586.22	\$90.79	\$5,715.78
* FID SEL HTH CARE SVC	240.583	\$16,555.95	\$137.58	\$33,099.41
* FID SEL TRANSPORT	72.855	\$6,220.00	\$108.78	\$7,925.17
* FID SEL NATURAL GAS	0.000	\$0.00	\$15.51	\$0.00
* FID SEL PHARMACEUTCL	364.714	\$5,606.96	\$23.72	\$8,651.02
* FID FREEDOM 2040	9,655.271	\$93,567.89	\$12.18	\$117,601.20
* FID TOTAL BOND	1,068.024	\$11,493.41	\$11.06	\$11,812.35
* FID FREEDOM 2025	240.550	\$2,589.20	\$15.38	\$3,699.66
* FID FREEDOM 2035	360.403	\$5,005.71	\$16.94	\$6,105.23
* FID FOCUSED HIGH INC	920.495	\$7,764.50	\$8.90	\$8,192.41
* FID LC VAL ENH INDX	2,782.331	\$34,593.28	\$16.03	\$44,600.77
* FID US BOND IDX	9,115.546	\$111,897.59	\$11.98	\$109,204.24
* FID 500 INDEX	724.703	\$68,352.72	\$165.32	\$119,807.90
* FID SM CAP IDX	383.148	\$11,019.16	\$27.56	\$10,559.56
* FID TOTAL MKT IDX	1,921.267	\$150,386.56	\$133.78	\$257,027.10
* FID INTL INDEX	178.260	\$6,946.58	\$49.29	\$8,786.44
* FID LT TR BD IDX	2,164.407	\$28,035.30	\$14.75	\$31,925.00
* FID STRATEGIC INCOME	7,739.618	\$96,356.49	\$12.69	\$98,215.75
* OUTSTANDING LOAN BALANCE				\$0.00

NET ASSETS 12/31/2021:				\$5,961,292.05
				=====

Assets are presented at fair value with the exception to fully benefit responsive investment contracts which are presented at contract value as in previous years.
See Chapter 7 of the Fidelity Auditor's Guide for financial statement presentation and disclosure information.

SUMMARY OF NET ASSETS

Total Plan Assets as of 12/31/2021

	<u>Fund Name</u>	<u>Share Balance</u> <u>12/31/2021</u>	<u>Historical Cost</u>	<u>Price</u>	<u>Total Market Value</u>
*	FID VALUE STRAT	1,350.389	\$44,138.62	\$51.81	\$69,963.65
*	FID MAGELLAN	17,687.076	\$172,887.26	\$15.37	\$271,850.36
*	FID CONTRAFUND	142.361	\$1,367.13	\$18.76	\$2,670.69
*	FID GROWTH COMPANY	1,636.952	\$26,627.10	\$36.47	\$59,699.64
*	FID VALUE	4,732.709	\$40,987.70	\$14.69	\$69,523.50
*	FID SEL BIOTECH	389.752	\$7,464.97	\$19.35	\$7,541.70
*	FID REAL ESTATE INVS	35.709	\$1,181.91	\$54.02	\$1,929.00
*	FID FOCUSED STOCK	339.758	\$7,497.20	\$34.72	\$11,796.40
*	FID MID CAP STOCK	1,899.419	\$61,361.07	\$42.18	\$80,117.49
*	FID SEL MED TECH&DV	64.951	\$2,432.02	\$83.18	\$5,402.62
*	FID INTL SMALL CAP	53.265	\$1,285.60	\$32.30	\$1,720.46
*	OUTSTANDING LOAN BALANCE				\$0.00

NET ASSETS 12/31/2021:					\$582,215.51
					=====

Assets are presented at fair value with the exception to fully benefit responsive investment contracts which are presented at contract value as in previous years.
See Chapter 7 of the Fidelity Auditor's Guide for financial statement presentation and disclosure information.

MetLife
 PLAN SUMMARY REPORT

GROUP NAME : MARY FREE BED HOSPITAL

RUN DATE: 05/06/2022

FOR PERIOD BEGINNING: 01-01-2021

ENDING: 12-31-2021

PAGE : 9

FUND			BEGINNING VALUE	CONTRI- BUTIONS	TRANSFERS IN	FUND TRANSFERS	DISTRI- BUTIONS	GAIN/LOSS	ENDING VALUE
TOTAL ACTIVE PARTICIPANTS :					19				
AG	8	EE	26,687.54	.00	.00	.00	6.74	3,540.03	30,220.83
		ER	2,586.27	.00	.00	.00	.00	343.09	2,929.36
TOTALS			29,273.81	.00	.00	.00	6.74	3,883.12	33,150.19
DS	1	EE	285.92	.00	.00	.00	14.04	35.15	307.03
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			285.92	.00	.00	.00	14.04	35.15	307.03
*GI	12	EE	81,038.96	.00	.00	-.82	40.69	2,430.90	83,428.35
		ER	1,476.27	.00	.00	.82	.00	44.30	1,521.39
TOTALS			82,515.23	.00	.00	.00	40.69	2,475.20	84,949.74
GR	9	EE	79,331.65	.00	.00	.00	10.32	18,260.87	97,582.20
		ER	3,628.50	.00	.00	.00	.00	835.30	4,463.80
TOTALS			82,960.15	.00	.00	.00	10.32	19,096.17	102,046.00
MC	8	EE	.00	.00	.00	.00	.00	.00	.00
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			.00	.00	.00	.00	.00	.00	.00
SC	6	EE	31,745.23	.00	.00	.00	9.96	3,265.37	35,000.64
		ER	1,070.60	.00	.00	.00	.00	110.13	1,180.73
TOTALS			32,815.83	.00	.00	.00	9.96	3,375.50	36,181.37
SI	13	EE	117,992.52	.00	.00	-2,518.75	11.62	31,496.54	146,958.69
		ER	6,949.96	.00	.00	.00	.00	1,860.71	8,810.67
TOTALS			124,942.48	.00	.00	-2,518.75	11.62	33,357.25	155,769.36
SM	8	EE	36,863.32	.00	.00	610.89	5,135.13	-4,068.86	28,270.22
		ER	2,017.36	.00	.00	.00	.00	-234.91	1,782.45
TOTALS			38,880.68	.00	.00	610.89	5,135.13	-4,303.77	30,052.67
IB	5	EE	17,474.83	.00	.00	.00	2,025.03	-303.58	15,146.22
		ER	1,102.27	.00	.00	.00	.00	-18.39	1,083.88
TOTALS			18,577.10	.00	.00	.00	2,025.03	-321.97	16,230.10
IN	6	EE	.00	.00	.00	.00	.00	.00	.00
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			.00	.00	.00	.00	.00	.00	.00
IT	8	EE	10,363.15	.00	.00	187.51	668.04	-173.72	9,708.90
		ER	951.29	.00	.00	.00	.00	-18.84	932.45
TOTALS			11,314.44	.00	.00	187.51	668.04	-192.56	10,641.35

MetLife
PLAN SUMMARY REPORT

GROUP NAME : MARY FREE BED HOSPITAL

RUN DATE: 05/06/2022

FOR PERIOD BEGINNING: 01-01-2021

ENDING: 12-31-2021

PAGE : 10

FUND			BEGINNING VALUE	CONTRI- BUTIONS	TRANSFERS IN	FUND TRANSFERS	DISTRI- BUTIONS	GAIN/LOSS	ENDING VALUE
GE	4	EE	.00	.00	.00	.00	.00	.00	.00
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			.00	.00	.00	.00	.00	.00	.00
OG	3	EE	38,867.83	.00	.00	.00	.00	5,569.44	44,437.27
		ER	826.44	.00	.00	.00	.00	118.43	944.87
TOTALS			39,694.27	.00	.00	.00	.00	5,687.87	45,382.14
AU	3	EE	4,646.84	.00	.00	-113.39	3,191.62	479.93	1,821.76
		ER	330.11	.00	.00	.00	.00	55.96	386.07
TOTALS			4,976.95	.00	.00	-113.39	3,191.62	535.89	2,207.83
AV	2	EE	1,109.07	.00	.00	-216.39	.00	321.84	1,214.52
		ER	334.76	.00	.00	.00	.00	102.11	436.87
TOTALS			1,443.83	.00	.00	-216.39	.00	423.95	1,651.39
JE	2	EE	8,749.15	.00	.00	-147.78	6,543.30	370.94	2,429.01
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			8,749.15	.00	.00	-147.78	6,543.30	370.94	2,429.01
LV	2	EE	103.70	.00	.00	.00	.00	24.89	128.59
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			103.70	.00	.00	.00	.00	24.89	128.59
LW	1	EE	2,236.78	.00	.00	-320.84	.00	513.07	2,429.01
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			2,236.78	.00	.00	-320.84	.00	513.07	2,429.01
MV	2	EE	.00	.00	.00	.00	.00	.00	.00
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			.00	.00	.00	.00	.00	.00	.00
PG	1	EE	.00	.00	.00	.00	.00	.00	.00
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			.00	.00	.00	.00	.00	.00	.00
GO	2	EE	3,327.03	.00	.00	.00	.00	681.52	4,008.55
		ER	.00	.00	.00	.00	.00	.00	.00
TOTALS			3,327.03	.00	.00	.00	.00	681.52	4,008.55
VV	2	EE	4,929.78	.00	.00	.00	5,416.82	487.04	.00
		ER	339.87	.00	.00	.00	.00	77.81	417.68
TOTALS			5,269.65	.00	.00	.00	5,416.82	564.85	417.68

MetLife
 PLAN SUMMARY REPORT

GROUP NAME : MARY FREE BED HOSPITAL

RUN DATE: 05/06/2022

FOR PERIOD BEGINNING: 01-01-2021

ENDING: 12-31-2021

PAGE : 11

FUND			BEGINNING VALUE	CONTRI- BUTIONS	TRANSFERS IN	FUND TRANSFERS	DISTRI- BUTIONS	GAIN/LOSS	ENDING VALUE
II	4	EE	17,126.08	.00	.00	1,620.27	.00	1,619.24	20,365.59
		ER	1,947.16	.00	.00	-2.00	.00	182.09	2,127.25
TOTALS			19,073.24	.00	.00	1,618.27	.00	1,801.33	22,492.84
* MX	4	EE	8,351.91	.00	.00	14.05	.00	1,899.81	10,265.77
		ER	891.07	.00	.00	.00	.00	203.67	1,094.74
TOTALS			9,242.98	.00	.00	14.05	.00	2,103.48	11,360.51
RI	2	EE	8,884.79	.00	.00	789.53	.00	1,157.99	10,832.31
		ER	244.28	.00	.00	.00	.00	32.03	276.31
TOTALS			9,129.07	.00	.00	789.53	.00	1,190.02	11,108.62
BI	3	EE	5,700.22	.00	.00	94.90	.00	-178.87	5,616.25
		ER	91.09	.00	.00	2.00	.00	-2.92	90.17
TOTALS			5,791.31	.00	.00	96.90	.00	-181.79	5,706.42
TOTALS			530,603.60	.00	.00	.00	23,073.31	71,120.11	578,650.40

MetLife
PLAN SUMMARY REPORT

GROUP NAME : MARY FREE BED HOSPITAL

RUN DATE: 05/06/2022

FOR PERIOD BEGINNING: 01-01-2021

ENDING: 12-31-2021

PAGE : 12

FUND	DESCRIPTION
AG	Frontier MidCap Gr Port
AU	Neuberger Brman Genesis
AV	VtrSycmr MidCp Val Port
BI	MET AGG BOND IDX
DS	BH/WELLINGTON BALANCED
GE	Invesco Global Equ Port
GI	Fix Int Acct
GO	Amer Funds Growth Fund
GR	BH/W LRG CP RRCH
IB	BlackRock Bond Income
II	METLIFE MSCI EAFE INDEX
IN	SSR Income
IT	Baillie Intnl Stock
JE	Jennison Growth
LV	MFS Value Portfolio
LW	MFS Value Portfolio E
MC	FI MC Opportunities
MV	Lord Abbett Mid Cap Val
MX	MetLife Mid Cap Stk Ind
OG	Invesco Global Equ Port
PG	Met/Putnam Voyager Fund
RI	MET RUSSELL 2000 INDEX
SC	TRP Small Cap Growth
SI	Stock Index
SM	MS Discovery Portfolio
VV	BH/WELLCREQIOPPR

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS HELD AT END OF YEAR

See complete related attachment under the audited financial statements attachment package.

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**

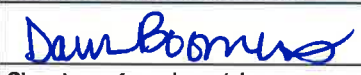
- A** This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instr.)
- ☒ a single-employer plan ☐ a DFE (specify) _____
- B** This return/report is: ☐ the first return/report ☐ the final return/report
- ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here ☐
- D** Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program
- ☐ special extension (enter description) _____
- 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 MARY FREE BED REHABILITATION HOSPITAL 403(B) PLAN		1b Three-digit plan number (PN) ▶ 002
		1c Effective date of plan 04/01/1987
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) MARY FREE BED REHABILITATION HOSPITAL		2b Employer Identification Number (EIN) 38-1359265
		2c Plan Sponsor's telephone number 616-840-8361
		2d Business code (see instructions) 622000
235 WEALTHY SE		
GRAND RAPIDS MI 49503-5299		

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		10-6-22	KAREN POWELL
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10-6-22	Dawn Boomers
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2021)
v. 210624

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
--	---

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
--	-----------------------------------

5 Total number of participants at the beginning of the plan year	5	2,874
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)	1,951
a (2) Total number of active participants at the end of the plan year	6a(2)	2,136
b Retired or separated participants receiving benefits	6b	44
c Other retired or separated participants entitled to future benefits	6c	1,171
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	3,351
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	2
f Total. Add lines 6d and 6e	6f	3,353
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	3,226
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	98
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 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) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
--	--

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

a Pension Schedules

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

b General Schedules

- (1)** ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information - Small Plan)
(3) ☒ **6** **A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____