

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br>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).<br><br><p style="text-align: center;">▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2021</b><br><br><b>This Form is Open to Public Inspection</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|

|               |                                                 |
|---------------|-------------------------------------------------|
| <b>Part I</b> | <b>Annual Report Identification Information</b> |
|---------------|-------------------------------------------------|

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

**A** This return/report is for:

☐ a multiemployer plan

☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)

☒ 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

☐ special extension (enter description)

☐ the DFVC program

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

|                |                                                               |
|----------------|---------------------------------------------------------------|
| <b>Part II</b> | <b>Basic Plan Information—enter all requested information</b> |
|----------------|---------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                     |                                                                  |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------|
| <b>1a</b> Name of plan<br><u>V. SANGIACOMO &amp; SONS 401(K) PLAN</u>                                                                                                                                                                                                                                                                                                         | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> </table>                                                                                                                                                                                                                                                                                   | <b>1b</b> Three-digit plan number (PN) ▶              | <u>001</u>                                                          |                                                                  |                                                             |
| <b>1b</b> Three-digit plan number (PN) ▶                                                                                                                                                                                                                                                                                                                                      | <u>001</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |                                                                     |                                                                  |                                                             |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br><u>V. SANGIACOMO &amp; SONS</u><br><br><u>21543 BROADWAY</u><br><u>PO BOX 324</u><br><u>SONOMA, CA 95476</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%;"><b>1c</b> Effective date of plan<br/><u>01/01/1987</u></td> </tr> <tr> <td style="width: 100%;"><b>2b</b> Employer Identification Number (EIN)<br/><u>94-1162486</u></td> </tr> <tr> <td style="width: 100%;"><b>2c</b> Plan Sponsor's telephone number<br/><u>707-938-5503</u></td> </tr> <tr> <td style="width: 100%;"><b>2d</b> Business code (see instructions)<br/><u>111300</u></td> </tr> </table> | <b>1c</b> Effective date of plan<br><u>01/01/1987</u> | <b>2b</b> Employer Identification Number (EIN)<br><u>94-1162486</u> | <b>2c</b> Plan Sponsor's telephone number<br><u>707-938-5503</u> | <b>2d</b> Business code (see instructions)<br><u>111300</u> |
| <b>1c</b> Effective date of plan<br><u>01/01/1987</u>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                     |                                                                  |                                                             |
| <b>2b</b> Employer Identification Number (EIN)<br><u>94-1162486</u>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                     |                                                                  |                                                             |
| <b>2c</b> Plan Sponsor's telephone number<br><u>707-938-5503</u>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                                                                     |                                                                  |                                                             |
| <b>2d</b> Business code (see instructions)<br><u>111300</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.

|                  |                                                   |            |                                                              |
|------------------|---------------------------------------------------|------------|--------------------------------------------------------------|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/14/2022 | STEVE SANGIACOMO                                             |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/14/2022 | LEAH ZAK                                                     |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |                                                   |            |                                                              |
|                  | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                                                                                                   |  | <b>3b</b> Administrator's EIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |     |
|                                                                                                                                                                                                                                                                                                                                                                                                                            |  | <b>3c</b> Administrator's telephone number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |     |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                     |  | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |     |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                    |  | <b>5</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 180 |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     |
| <b>a(1)</b> Total number of active participants at the beginning of the plan year.....                                                                                                                                                                                                                                                                                                                                     |  | <b>6a(1)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 175 |
| <b>a(2)</b> Total number of active participants at the end of the plan year .....                                                                                                                                                                                                                                                                                                                                          |  | <b>6a(2)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 162 |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                                                                                                                                                                                                                                                                                         |  | <b>6b</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2   |
| <b>c</b> Other retired or separated participants entitled to future benefits .....                                                                                                                                                                                                                                                                                                                                         |  | <b>6c</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4   |
| <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....                                                                                                                                                                                                                                                                                                                                                |  | <b>6d</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 168 |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....                                                                                                                                                                                                                                                                                                                 |  | <b>6e</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0   |
| <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....                                                                                                                                                                                                                                                                                                                                                                    |  | <b>6f</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 168 |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....                                                                                                                                                                                                                                                                            |  | <b>6g</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 166 |
| <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....                                                                                                                                                                                                                                                                                 |  | <b>6h</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0   |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....                                                                                                                                                                                                                                                                                        |  | <b>7</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |     |
| <b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:<br>2E 2J 2F 2G 2K 3B 2T                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     |
| <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     |
| <b>9a</b> Plan funding arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor                                                                                                                   |  | <b>9b</b> Plan benefit arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor                                                                                                                                                                                                                         |     |
| <b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     |
| <b>a Pension Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)<br><br>(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br><br>(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary |  | <b>b General Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)<br>(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)<br>(3) <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information)<br>(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)<br>(5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)<br>(6) <input type="checkbox"/> <b>G</b> (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 \_\_\_\_\_

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2021</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021 |                                                      |
| A Name of plan<br>V. SANGIACOMO & SONS 401(K) PLAN                                         | B Three-digit plan number (PN) ▶ 001                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>V. SANGIACOMO & SONS             | D Employer Identification Number (EIN)<br>94-1162486 |

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

1 Coverage Information:

(a) Name of insurance carrier  
MASSACHUSETTS MUTUAL 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     |
| 04-1590850 | 65935         | MR 60768                              | 168                                                                         | 01/01/2021              | 12/31/2021 |

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

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|                                      |                               |

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

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

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

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

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

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|          |                                                                                               |          |          |
|----------|-----------------------------------------------------------------------------------------------|----------|----------|
| <b>4</b> | Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |          |
| <b>5</b> | Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> | <b>0</b> |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

|          |                                                                                                                                                                                                       |           |  |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--|
| <b>b</b> | Premiums paid to carrier .....                                                                                                                                                                        | <b>6b</b> |  |
| <b>c</b> | Premiums due but unpaid at the end of the year .....                                                                                                                                                  | <b>6c</b> |  |
| <b>d</b> | 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

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

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

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

|          |                                               |           |               |
|----------|-----------------------------------------------|-----------|---------------|
| <b>b</b> | Balance at the end of the previous year ..... | <b>7b</b> | <b>250194</b> |
|----------|-----------------------------------------------|-----------|---------------|

|          |                                                              |              |              |  |
|----------|--------------------------------------------------------------|--------------|--------------|--|
| <b>c</b> | Additions: (1) Contributions deposited during the year ..... | <b>7c(1)</b> | <b>16089</b> |  |
|          | (2) Dividends and credits.....                               | <b>7c(2)</b> | <b>0</b>     |  |
|          | (3) Interest credited during the year.....                   | <b>7c(3)</b> | <b>3452</b>  |  |
|          | (4) Transferred from separate account.....                   | <b>7c(4)</b> | <b>1534</b>  |  |
|          | (5) Other (specify below) .....                              | <b>7c(5)</b> | <b>0</b>     |  |

|                           |              |              |
|---------------------------|--------------|--------------|
| (6) Total additions ..... | <b>7c(6)</b> | <b>21075</b> |
|---------------------------|--------------|--------------|

|          |                                                                              |           |               |
|----------|------------------------------------------------------------------------------|-----------|---------------|
| <b>d</b> | Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) ..... | <b>7d</b> | <b>271269</b> |
|----------|------------------------------------------------------------------------------|-----------|---------------|

|          |                                                                           |              |              |  |
|----------|---------------------------------------------------------------------------|--------------|--------------|--|
| <b>e</b> | Deductions:                                                               |              |              |  |
|          | (1) Disbursed from fund to pay benefits or purchase annuities during year | <b>7e(1)</b> | <b>15836</b> |  |
|          | (2) Administration charge made by carrier.....                            | <b>7e(2)</b> | <b>1972</b>  |  |
|          | (3) Transferred to separate account.....                                  | <b>7e(3)</b> | <b>0</b>     |  |
|          | (4) Other (specify below) .....                                           | <b>7e(4)</b> | <b>0</b>     |  |

|                            |              |              |
|----------------------------|--------------|--------------|
| (5) Total deductions ..... | <b>7e(5)</b> | <b>17808</b> |
|----------------------------|--------------|--------------|

|          |                                                                                                |           |               |
|----------|------------------------------------------------------------------------------------------------|-----------|---------------|
| <b>f</b> | Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) ..... | <b>7f</b> | <b>253461</b> |
|----------|------------------------------------------------------------------------------------------------|-----------|---------------|

**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:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> |  |
| <b>b</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. ....<br>Specify nature of costs. | <b>10b</b> |  |

**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. ▶

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

|                                                                                            |                                                             |     |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----|
| For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021 |                                                             |     |
| <b>A</b> Name of plan<br>V. SANGIACOMO & SONS 401(K) PLAN                                  | <b>B</b> Three-digit plan number (PN) ▶                     | 001 |
|                                                                                            |                                                             |     |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>V. SANGIACOMO & SONS      | <b>D</b> Employer Identification Number (EIN)<br>94-1162486 |     |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

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

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**(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

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**(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

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**(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

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

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

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

GREAT WEST LIFE & ANNUITY INSURANCE

84-0467907

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52 60 62<br>64 68 72   | CONTRACT ADMINISTRATOR                                                                            | 74269                                                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

CAPFINANCIAL PARTNERS, LLC

26-0058143

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 27                     | INVESTMENT ADVISOR                                                                                | 27622                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

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

PISENTI & BRINKER LLP

94-1585562

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 10                     | AUDITOR                                                                                           | 23000                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

**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)

CAPFINANCIAL PARTNERS LLC

26-0058143

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 27                     | INVESTMENT ADVISORY SERVI                                                                         | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 12347                                                                                                                                                                           | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

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

ALLSPRING

84-6615098

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

AMERICAN FUNDS

94-6050854

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

**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)

BLACKROCK

13-2949519

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

FIDELITY INVESTMENTS

04-3365630

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

GOLDMAN SACHS

13-4166989

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

**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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 64                     | RECORDKEEPING                                                                                     | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

INVESCO

13-2649093

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

JANUS HENDERSON

84-0592523

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

**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)

JP MORGAN

26-3613641

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

MFS INVESTMENT MANAGEMENT

04-3158862

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

T. ROWE PRICE

52-1784828

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

**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)

VANGUARD

23-2311358

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

VANGUARD

23-1999755

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52                     | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

MASSACHUSETTS MUTUAL LIFE INS. CO.

04-1590850

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 52 72                  | INVESTMENT PROVIDER                                                                               | 0                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 60                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MFS GROWTH FUND<br><br>04-3158862                                   | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| MASSACHUSETTS MUTUAL LIFE INS. CO.                                  | 72 52                                                                                                                                                              | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MASSMUTUAL US GOVERNMENT MNY MKT FD<br><br>04-3212059               | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| MASSACHUSETTS MUTUAL LIFE INS. CO.                                  | 72 52                                                                                                                                                              | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MASSMUTUAL OVERSEAS FUND<br><br>04-3557000                          | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                     | 60                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| INVESCO GLOBAL FUND<br><br>13-2649093                               | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                     | 60                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BLACKROCK TOTAL RETURN FUND<br><br>13-2949519                       | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                     | 60                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| GOLDMAN SACHS SMALL CAP VALUE FUND<br><br>13-4166989                | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 60                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| T. ROWE PRICE MID-CAP GROWTH FUND<br><br>52-1784828                 | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 60                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| JANUS HENDERSON TRITON FD<br><br>84-0592523                         | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 60                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| ALLSPRING SPECIAL MID CAP VAL FD<br><br>84-6615098                  | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 60                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| AMER FUNDS BALANCED FUND<br><br>94-6050854                          | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| CAPFINANCIAL PARTNERS LLC                                           | 27                                                                                                                                                                 | 12347                                     |
| (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. |                                           |
| GREAT WEST LIFE & ANNUITY INSURANCE<br><br>84-0467907               | PLAN RELATED EXPENSES                                                                                                                                              |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| ALLSPRING                                                           | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| ALLSPRING SPECIAL MID CAP VAL FD<br><br>84-6615098                  | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN FUNDS                                                      | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| AMER FUNDS BALANCED FUND<br><br>94-6050854                          | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| BLACKROCK                                                           | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| BLACKROCK TOTAL RETURN FUND<br><br>13-2949519                       | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| FIDELITY INVESTMENTS                                                | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| FIDELITY 500 INDEX FUND<br><br>04-3365630                           | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| GOLDMAN SACHS                                                       | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| GOLDMAN SACHS SMALL CAP VALUE FUND<br><br>13-4166989                | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| GREAT WEST LIFE & ANNUITY INSURANCE                                 | 49                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MILLENNIUM TRUST COMPANY, LLC<br><br>36-4400066                     | REFERRAL FEE                                                                                                                                                       |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| INVESCO                                                             | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| INVESCO GLOBAL FUND<br><br>13-2649093                               | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| JANUS HENDERSON                                                     | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| JANUS HENDERSON TRITON FD<br><br>84-0592523                         | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| JP MORGAN                                                           | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| JP MORGAN EQUITY INCOME FUND<br><br>26-3613641                      | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| MFS INVESTMENT MANAGEMENT                                           | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MFS GROWTH FUND<br><br>04-3158862                                   | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| T. ROWE PRICE                                                       | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| T. ROWE PRICE MID-CAP GROWTH FUND<br><br>52-1784828                 | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| CLOSED VANGUARD INSTL TARGET R<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| CLOSED VANGUARD INSTL TRGT RET<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD TARGET RETMNT 2015 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD TARGET RETMNT 2020 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD TARGET RETMNT 2025 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2030 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2035 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2040 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2045 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2050 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| VANGUARD                                                            | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| VANGUARD TARGET RETMNT 2055 FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                         |                                           |

**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<br>(see instructions) | (c) Enter amount of indirect<br>compensation |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                            |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD TARGET RETMNT INCM FD<br><br>23-2311358                    | BASIS POINTS * PLAN ASSETS                                                                                                                                               |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect<br>compensation |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                            |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD MID CAP INDEX FUND<br><br>23-1999755                       | BASIS POINTS * PLAN ASSETS                                                                                                                                               |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect<br>compensation |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| VANGUARD                                                | 52                                      | 0                                            |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VANGUARD SMALL CAP INDEX FUND<br><br>23-1999755                     | BASIS POINTS * PLAN ASSETS                                                                                                                                               |

**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)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:



**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

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                              |                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>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).<br><br><b>► File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2021</b><br><br><b>This Form is Open to Public Inspection</b> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

|                                                                                                          |                                                                    |            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| For calendar plan year 2021 or fiscal plan year beginning <b>01/01/2021</b> and ending <b>12/31/2021</b> |                                                                    |            |
| <b>A</b> Name of plan<br><b>V. SANGIACOMO &amp; SONS 401(K) PLAN</b>                                     | <b>B</b> Three-digit plan number (PN) ►                            | <b>001</b> |
|                                                                                                          |                                                                    |            |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>V. SANGIACOMO &amp; SONS</b>         | <b>D</b> Employer Identification Number (EIN)<br><b>94-1162486</b> |            |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**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 |
|---------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash.....                                                      | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                      |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                           | <b>1b(1)</b>    | 2847                  | 2205            |
| <b>(2)</b> Participant contributions.....                                                         | <b>1b(2)</b>    | 5326                  | 4277            |
| <b>(3)</b> Other .....                                                                            | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:                                                                     |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....  | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities .....                                                       | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                           |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....                                                                        | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                     |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....                                                                           | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                              | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                  | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                               | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....                                                                | <b>1c(8)</b>    | 0                     | 0               |
| <b>(9)</b> Value of interest in common/collective trusts .....                                    | <b>1c(9)</b>    | 749                   | 759             |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                   | <b>1c(10)</b>   | 0                     | 0               |
| <b>(11)</b> Value of interest in master trust investment accounts .....                           | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                 | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....       | <b>1c(13)</b>   | 10169415              | 11709257        |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)..... | <b>1c(14)</b>   | 250194                | 253461          |
| <b>(15)</b> Other.....                                                                            | <b>1c(15)</b>   | 0                     | 0               |

|                    |                                                                  | (a) Beginning of Year | (b) End of Year |
|--------------------|------------------------------------------------------------------|-----------------------|-----------------|
| <b>1d</b>          | Employer-related investments:                                    |                       |                 |
| (1)                | Employer securities.....                                         | 1d(1) 0               | 0               |
| (2)                | Employer real property.....                                      | 1d(2)                 |                 |
| <b>e</b>           | Buildings and other property used in plan operation .....        | 1e                    |                 |
| <b>f</b>           | Total assets (add all amounts in lines 1a through 1e) .....      | 1f 10428531           | 11969959        |
| <b>Liabilities</b> |                                                                  |                       |                 |
| <b>g</b>           | Benefit claims payable .....                                     | 1g                    |                 |
| <b>h</b>           | Operating payables .....                                         | 1h                    |                 |
| <b>i</b>           | Acquisition indebtedness.....                                    | 1i                    |                 |
| <b>j</b>           | Other liabilities.....                                           | 1j                    |                 |
| <b>k</b>           | Total liabilities (add all amounts in lines 1g through 1j) ..... | 1k 0                  | 0               |
| <b>Net Assets</b>  |                                                                  |                       |                 |
| <b>l</b>           | Net assets (subtract line 1k from line 1f) .....                 | 1l 10428531           | 11969959        |

**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 |
|----------|-----------------------------------------------------------------------------------------------------|-----------------|-----------|
| <b>a</b> | <b>Contributions:</b>                                                                               |                 |           |
| (1)      | Received or receivable in cash from: <b>(A)</b> Employers .....                                     | 2a(1)(A) 210038 |           |
|          | <b>(B)</b> Participants .....                                                                       | 2a(1)(B) 431240 |           |
|          | <b>(C)</b> Others (including rollovers).....                                                        | 2a(1)(C) 0      |           |
| (2)      | Noncash contributions.....                                                                          | 2a(2)           |           |
| (3)      | Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2) .....                             | 2a(3)           | 641278    |
| <b>b</b> | <b>Earnings on investments:</b>                                                                     |                 |           |
| (1)      | Interest:                                                                                           |                 |           |
|          | <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A)        |           |
|          | <b>(B)</b> U.S. Government securities .....                                                         | 2b(1)(B)        |           |
|          | <b>(C)</b> Corporate debt instruments .....                                                         | 2b(1)(C)        |           |
|          | <b>(D)</b> Loans (other than to participants) .....                                                 | 2b(1)(D)        |           |
|          | <b>(E)</b> Participant loans.....                                                                   | 2b(1)(E) 0      |           |
|          | <b>(F)</b> Other .....                                                                              | 2b(1)(F) 3452   |           |
|          | <b>(G)</b> Total interest. Add lines 2b(1)(A) through (F).....                                      | 2b(1)(G)        | 3452      |
| (2)      | Dividends: <b>(A)</b> Preferred stock.....                                                          | 2b(2)(A)        |           |
|          | <b>(B)</b> Common stock .....                                                                       | 2b(2)(B) 0      |           |
|          | <b>(C)</b> Registered investment company shares (e.g. mutual funds).....                            | 2b(2)(C) 274517 |           |
|          | <b>(D)</b> Total dividends. Add lines 2b(2)(A), (B), and (C) .....                                  | 2b(2)(D)        | 274517    |
| (3)      | Rents .....                                                                                         | 2b(3)           |           |
| (4)      | Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                              | 2b(4)(A)        |           |
|          | <b>(B)</b> Aggregate carrying amount (see instructions).....                                        | 2b(4)(B)        |           |
|          | <b>(C)</b> Subtract line 2b(4)(B) from line 2b(4)(A) and enter result .....                         | 2b(4)(C)        |           |
| (5)      | Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....                      | 2b(5)(A)        |           |
|          | <b>(B)</b> Other .....                                                                              | 2b(5)(B)        |           |
|          | <b>(C)</b> 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)  |            | 10        |
| (7) Net investment gain (loss) from pooled separate accounts.....                              | 2b(7)  |            | 0         |
| (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) |            | 1227735   |
| c Other income.....                                                                            | 2c     |            | 0         |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total.....               | 2d     |            | 2146992   |
| <b>Expenses</b>                                                                                |        |            |           |
| e Benefit payment and payments to provide benefits:                                            |        |            |           |
| (1) Directly to participants or beneficiaries, including direct rollovers.....                 | 2e(1)  | 480673     |           |
| (2) To insurance carriers for the provision of benefits.....                                   | 2e(2)  | 0          |           |
| (3) Other.....                                                                                 | 2e(3)  | 0          |           |
| (4) Total benefit payments. Add lines 2e(1) through (3).....                                   | 2e(4)  |            | 480673    |
| f Corrective distributions (see instructions).....                                             | 2f     |            | 0         |
| g Certain deemed distributions of participant loans (see instructions).....                    | 2g     |            | 0         |
| h Interest expense.....                                                                        | 2h     |            |           |
| i Administrative expenses: (1) Professional fees.....                                          | 2i(1)  | 23000      |           |
| (2) Contract administrator fees.....                                                           | 2i(2)  | 2240       |           |
| (3) Investment advisory and management fees.....                                               | 2i(3)  | 99651      |           |
| (4) Other.....                                                                                 | 2i(4)  | 0          |           |
| (5) Total administrative expenses. Add lines 2i(1) through (4).....                            | 2i(5)  |            | 124891    |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....            | 2j     |            | 605564    |
| <b>Net Income and Reconciliation</b>                                                           |        |            |           |
| k Net income (loss). Subtract line 2j from line 2d.....                                        | 2k     |            | 1541428   |
| 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: PISENTI & BRINKER LP

(2) EIN: 91-1585562

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>b</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.) ..... |     |    |         |
| <b>4b</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>c</b> 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.) .....                                                                                                                             |     |    |         |
| <b>4c</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>d</b> 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.) .....                                                                                                                  |     |    |         |
| <b>4d</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                                                                                                         | X   |    | 1000000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                          |     | X  |         |
| <b>4f</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>g</b> 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? .....                                                                                                                                       |     |    |         |
| <b>4g</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>h</b> 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? .....                                                                                                                             |     |    |         |
| <b>4h</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                                                                                                   | X   |    |         |
| <b>4i</b>                                                                                                                                                                                                                                                                                                        | X   |    |         |
| <b>j</b> 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   |    |         |
| <b>4j</b>                                                                                                                                                                                                                                                                                                        | X   |    |         |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                                                                                                              |     | X  |         |
| <b>4k</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                               |     | X  |         |
| <b>4l</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                                                                                                     |     | X  |         |
| <b>4m</b>                                                                                                                                                                                                                                                                                                        |     | X  |         |
| <b>n</b> 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. ....                                                                                                                         |     |    |         |
| <b>4n</b>                                                                                                                                                                                                                                                                                                        |     |    |         |

**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 \_\_\_\_\_.

|                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                  |                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <div>SCHEDULE R<br/>(Form 5500)<br/><br/>Department of the Treasury<br/>Internal Revenue Service<br/><br/>Department of Labor<br/>Employee Benefits Security Administration<br/><br/>Pension Benefit Guaranty Corporation</div> | <div>Retirement Plan Information</div> <div>This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).</div> <div>► File as an attachment to Form 5500.</div> | <div>OMB No. 1210-0110</div> <div>2021</div> <div>This Form is Open to Public Inspection.</div> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|

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

|                                                                                       |                                                             |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A</b> Name of plan<br>V. SANGIACOMO & SONS 401(K) PLAN                             | <b>B</b> Three-digit plan number (PN) ►<br>001              |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>V. SANGIACOMO & SONS | <b>D</b> Employer Identification Number (EIN)<br>94-1162486 |

|               |                      |
|---------------|----------------------|
| <b>Part I</b> | <b>Distributions</b> |
|---------------|----------------------|

All references to distributions relate only to payments of benefits during the plan year.

|                                                                                                                                                                                                                                                             |          |   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....                                                                                                                       | <b>1</b> | 0 |
| <b>2</b> 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):<br><br>EIN(s): 04-1590850 |          |   |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                            |          |   |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year .....                                                                                                                            | <b>3</b> |   |

|                |                                                                                                                                                                               |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II</b> | <b>Funding Information</b> (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.) |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                    |                              |                             |                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....                                                                                                                                                                                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                                                                                                                               |                              |                             |                              |
| <b>5</b> 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. <b>Date:</b> Month _____ Day _____ Year _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                             |                              |
| <b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....                                                                                                                                                                                                                     | <b>6a</b>                    |                             |                              |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                         | <b>6b</b>                    |                             |                              |
| <b>c</b> 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) .....                                                                                                                                                                                                                   | <b>6c</b>                    |                             |                              |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                                                                                                                                      |                              |                             |                              |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>8</b> 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? .....                                                                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|                 |                   |
|-----------------|-------------------|
| <b>Part III</b> | <b>Amendments</b> |
|-----------------|-------------------|

|                                                                                                                                                                                                                            |                                   |                                   |                               |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| <b>9</b> 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..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|                |                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part IV</b> | <b>ESOPs</b> (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. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</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.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 \_\_\_\_\_



## **V. Sangiacomo & Sons 401(k) Plan**

*Financial Statements with Supplementary Information  
and  
Independent Auditor's Report  
for the year ended December 31, 2021  
and as of  
December 31, 2020*



**PISENTI & BRINKER** LLP  
Certified Public Accountants & Advisors

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## Independent Auditor's Report

To the Plan Trustee  
V. Sangiacomo & Sons 401(k) Plan  
Sonoma, California

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

We have performed an audit of the financial statements of V. Sangiacomo & Sons 401(k) Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statements of net assets available for benefits as of December 31, 2021, the related statements of changes in net 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 (DOL) 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 DOL'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 C to the financial statements, is complete and accurate.

### Opinion on the 2021 Financial Statements

In our opinion, based on our audit and on the procedures performed as described in the Auditor's Responsibilities for the Audit of the 2021 Financial Statements section:

- The amounts and disclosures in the accompanying 2021 financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).
- The information in the accompanying 2021 financial statements related to assets held by and certified to by a qualified institution agrees to or is derived from, in all material respects, the information prepared and certified by an institution that management determined meet the requirements of ERISA Section 103(a)(3)(C).

## **Independent Auditor's Report (continued)**

### **Basis for Opinion on the 2021 Financial Statements**

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the 2021 Financial Statements section of our report.

We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

### **Responsibilities of Management for the 2021 Financial Statements**

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

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

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit of the 2021 Financial Statements section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists.

The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

## **Independent Auditor's Report (continued)**

### **Auditor's Responsibilities for the Audit of the 2021 Financial Statements (continued)**

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

Our audit did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the 2021 financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of U.S. GAAP.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with U.S. GAAP.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

### **Other Matters**

#### **2021 Supplemental Schedule Required by ERISA**

The supplemental schedule listed in the table of contents is presented for purposes of additional analysis and are not a required part of the financial statements but is supplementary information required by the DOL'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.

## **Independent Auditor's Report (continued)**

### **2021 Supplemental Schedule Required by ERISA (continued)**

The information included in the supplemental schedule, other than that agreed to or derived from the certified investment information, has been subjected to auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. For information included in the supplemental schedule that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedule, we evaluated whether the supplemental schedule, other than the information agreed to or derived from the certified investment information, including its form and content, is presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion:

- The form and content of the supplemental schedule, other than the information in the supplemental schedule that agreed to or is derived from the certified investment information, are presented, in all material respects, in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.
- The information in the supplemental schedule related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

### **Auditor's Report on the 2020 Financial Statements**

We were engaged to audit the 2020 financial statements of the Plan. As permitted by 29 CFR 2520.103-8 of the DOL's Rules and Regulations for Reporting and Disclosure under ERISA, the plan administrator instructed us not to perform and we did not perform any auditing procedures with respect to the information certified by a qualified institution. In our report dated October 13, 2021, we indicated that (a) 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, and (b) the form and content of the information included in the 2020 financial statements other than that derived from the certified information were presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.



Santa Rosa, California  
October 11, 2022

**V. Sangiacomo & Sons 401(k) Plan**  
**Statements of Net Assets Available for Benefits**

| <b>December 31,</b>                              | <b>2021</b>          | <b>2020</b>          |
|--------------------------------------------------|----------------------|----------------------|
| <b>Assets</b>                                    |                      |                      |
| Investments, at fair value:                      |                      |                      |
| Mutual funds                                     | \$ 11,709,257        | \$ 10,169,415        |
| Collective trust fund                            | 759                  | 749                  |
| Total assets at fair value                       | 11,710,016           | 10,170,164           |
| Investment at contract value, guaranteed account | 253,461              | 250,194              |
| Receivables:                                     |                      |                      |
| Participant contributions                        | 4,277                | 5,326                |
| Employer contributions                           | 2,205                | 2,847                |
| Total receivables                                | 6,482                | 8,173                |
| <b>Net assets available for benefits</b>         | <b>\$ 11,969,959</b> | <b>\$ 10,428,531</b> |

See accompanying notes.

**V. Sangiacomo & Sons 401(k) Plan**  
**Statement of Changes in Net Assets Available for Benefits**

**Year Ended December 31, 2021**

**Additions to net assets attributed to:**

Contributions:

|             |            |
|-------------|------------|
| Participant | \$ 431,240 |
| Employer    | 210,038    |

641,278

Investment activity:

|                                               |           |
|-----------------------------------------------|-----------|
| Net appreciation in fair value of investments | 1,227,745 |
| Interest and dividends                        | 277,969   |

1,505,714

Total additions

2,146,992

**Deductions from net assets attributed to:**

|                               |         |
|-------------------------------|---------|
| Benefits paid to participants | 480,673 |
| Administrative expenses       | 124,891 |

Total deductions

605,564

**Net increase in net assets**

1,541,428

**Net assets available for benefits:**

|                   |            |
|-------------------|------------|
| Beginning of year | 10,428,531 |
|-------------------|------------|

|             |               |
|-------------|---------------|
| End of year | \$ 11,969,959 |
|-------------|---------------|

See accompanying notes.

Year Ended December 31, 2021 and as of December 31, 2020

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**Note A. Description of the Plan**

The following brief description of the V. Sangiacomo & Sons 401(k) Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

*General*

The Plan was established on January 1, 1987, as a defined contribution retirement plan covering substantially all employees of V. Sangiacomo & Sons, dba Sangiacomo Family Vineyards, LLP, Sonoma Valley Vineyards, Inc., and Balbi, Inc. (collectively referred to as the "Company") who have completed at least one year of service. There is a minimum age requirement of 18 to participate. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"). V. Sangiacomo & Sons is the Plan's Sponsor and serves as Plan Administrator. The financial statements are prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP").

*Contributions*

Each year, participants may contribute up to 100% of pretax annual compensation, as defined in the Plan. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans ("rollover").

The Company contributes a safe harbor contribution of 100% of the first 3% of base compensation that a participant contributes to the Plan plus 50% of the participant's contribution between 3% and 5% of base compensation. Additional amounts may be contributed at the option of the Company. Contributions are subject to certain Internal Revenue Service limitations.

*Participant Accounts*

Each participant's account is credited with the participant's contributions and allocations of (a) the Company's contributions and, (b) Plan earnings (losses), and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account balance. The investment direction for the account is provided by the participant.

*Vesting*

Participants are immediately 100% vested in their elective deferrals, qualified nonelective contributions, and rollover contributions plus actual earnings thereon. Participants are immediately 100% vested in the Company's safe harbor matching contributions.

Year Ended December 31, 2021 and as of December 31, 2020

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**Note A. Description of the Plan (continued)**

*Payment of Benefits*

Upon termination of service due to death, disability, retirement, or other reasons, a participant may elect to receive a lump-sum payment in an amount equal to the value of the participant's vested portion of their account. In the event of termination of employment before retirement, a participant will be entitled to receive their vested account balance. If a terminated participant's vested account balance is greater than \$5,000, such participant may leave their funds in the Plan. If the terminated participant's vested account balance is equal to or less than \$5,000, the Company may elect to distribute the participant's funds without consent.

If the termination is due to retirement and the participant has attained age 59½ (early retirement) or 65 (normal retirement) and is 100% vested in their account, the participant is entitled to all of their account balance and may elect to receive all or any portion of the balance.

**Note B. Summary of Significant Accounting Policies**

*Basis of Accounting*

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

*Use of Estimates*

The preparation of financial statements in conformity with GAAP requires the Plan Administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

*Investment Valuation and Revenue Recognition*

Except for certain investments described in Note E, the Plan's investments are recorded at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Investment Committee determines the Plan's valuation policies utilizing information provided by the trustee. See Note D for a discussion of fair value measurements.

Securities transactions are accounted for on the trade date (the date the order to buy or sell is executed). Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation or depreciation in fair value of investments includes the change in market value of all Plan investments (including investments bought and sold as well as those held during the year).

*Payment of Benefits*

Benefits are recorded when paid.

*Expenses*

Certain expenses of maintaining the Plan are paid by the Plan, unless otherwise paid by the Company. Expenses that are paid by the Company are excluded from these financial statements. Investment related expenses are included as a reduction of net appreciation of fair value of investments.

Year Ended December 31, 2021 and as of December 31, 2020

**Note C. Information Certified and Provided by Reliance Trust Company**

The following is a summary of the Plan's asset information as of December 31, 2021 and 2020, and for the year ended December 31, 2021, included throughout the Plan's financial statements and ERISA-required supplemental schedule, obtained by management and agreed to or derived from information certified by Reliance Trust Company ("the trustee") of the Plan. The Plan Administrator has obtained certifications from the trustee that information provided to the Plan Administrator by the trustee related to the following assets is complete and accurate. Accordingly, as permitted by 29 CFR 2520.103-8 of the DOL's Rules and Regulations for Reporting and Disclosure under ERISA, the Plan Administrator instructed the Plan's independent auditors not to perform any auditing procedures with respect to information which appears throughout the financial statements and ERISA-required supplemental schedule related to the following assets:

| Description                 | 2021          | 2020          |
|-----------------------------|---------------|---------------|
| Mutual funds                | \$ 11,709,257 | \$ 10,169,415 |
| Guaranteed interest account | 253,461       | 250,194       |
| Collective trust fund       | 759           | 749           |

The trustee also certified the completeness and accuracy of \$1,227,745 of net appreciation in the fair value of investments and \$277,969 of interest and dividend income related to the assets listed above for the year ended December 31, 2021.

**Note D. Fair Value Measurements**

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under Financial Accounting Standards Board Accounting Standards Codification 820 are described as follows:

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Level 1</b> | Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Level 2</b> | Inputs to the valuation methodology include: <ul style="list-style-type: none"><li>• quoted prices for similar assets or liabilities in active markets;</li><li>• quoted prices for identical or similar assets or liabilities in inactive markets;</li><li>• inputs other than quoted prices that are observable for the asset or liability;</li><li>• inputs that are derived principally from or corroborated by observable market data by correlation or other means.</li></ul> 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. |
| <b>Level 3</b> | Inputs to the valuation methodology are unobservable and significant to the fair value measurement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

Year Ended December 31, 2021 and as of December 31, 2020

**Note D. Fair Value Measurements (continued)**

The asset 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 maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value:

*Mutual funds:* Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

*Collective trust fund:* Valued at the NAV of units of a bank collective trust. The NAV, as provided by the trustees, is used as a practical expedient to estimate fair value. The NAV is based on the fair value of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported NAV. Participant transactions (purchases and sales) may occur daily. Were the Plan to initiate a full redemption of the collective trust, the investment adviser reserves the right to temporarily delay withdrawal from the trust in order to ensure that securities liquidations will be carried out in an orderly business manner.

The preceding methods described may produce a fair value calculation 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 following table sets forth by level, within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2021:

|                                          | Level 1       | Level 2 | Level 3 | Total         |
|------------------------------------------|---------------|---------|---------|---------------|
| Mutual funds                             | \$ 11,709,257 | \$ -    | \$ -    | \$ 11,709,257 |
| Collective trust fund                    | -             | 759     | -       | 759           |
| Total assets in the fair value hierarchy | \$ 11,709,257 | \$ 759  | \$ -    | \$ 11,710,016 |

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**Year Ended December 31, 2021 and as of December 31, 2020**

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**Note D. Fair Value Measurements (continued)**

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

|                                             | Level 1       | Level 2 | Level 3 | Total         |
|---------------------------------------------|---------------|---------|---------|---------------|
| Mutual funds                                | \$ 10,169,415 | \$ -    | \$ -    | \$ 10,169,415 |
| Collective trust fund                       | -             | 749     | -       | 749           |
| Total assets in the<br>fair value hierarchy | \$ 10,169,415 | \$ 749  | \$ -    | \$ 10,170,164 |

**Note E. Fully Benefit-Responsive Investment Contract**

The Plan holds a traditional investment contract. This contract meets the fully benefit-responsive investment contract criteria and therefore is reported at contract value. Contract value is the relevant measure for fully benefit-responsive investment contracts because this is the amount received by participants if they were to initiate permitted transactions under the terms of the Plan. Contract value represents contributions made under each contract, plus earnings, less participant withdrawals, and administrative expenses. The contract value of these investments totaled \$253,461 and \$250,194 at December 31, 2021 and 2020, respectively.

The Plan's ability to receive amounts due in accordance with fully benefit-responsive investment contracts is dependent on the third-party issuer's ability to meet its financial obligations. The issuer's ability to meet its contractual obligations may be affected by future economic and regulatory developments.

Certain events might limit the ability of the Plan to transact at contract value with the contract issuer. These events may be different under each contract. Examples of such events include the following:

1. The Plan's failure to qualify under Section 401(a) of the Internal Revenue Code or the failure of the trust to be tax-exempt under Section 501(a) of the Internal Revenue Code,
2. Premature termination of the contract,
3. Plan termination or merger,
4. Changes to the Plan's prohibition on competing investment options, and
5. Bankruptcy of the Plan sponsor or other Plan sponsor events that significantly affect the Plan's normal operations.

No events are currently known to be probable of occurring that might limit the ability of the Plan to transact at contract value with the contract issuers and that also would limit the ability of the Plan to transact at contract value with the participants.

In addition, certain events allow the issuer to terminate the contracts with the Plan and settle at an amount different from contract value. Examples of such events include the following:

1. An uncured violation of the Plan's investment guidelines,
2. A breach of material obligation under the contract,
3. A material misrepresentation, and
4. A material amendment to the agreements without the consent of the issuer.

Year Ended December 31, 2021 and as of December 31, 2020

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**Note F. Party-In-Interest Transactions**

Party-in-interest transactions include those with fiduciaries or employees of the Plan, any person who provides services to the Plan, an employer whose employees are covered by the Plan, an employee organization whose members are covered by the Plan, a person who owns 50% or more of such employer association, or relatives of such person. Reliance Trust Company, the Plan's trustee, Massachusetts Mutual Life Insurance Company, the Plan's record-keeper and Pisenti & Brinker LLP, the Plan's auditor are all considered parties-in-interest according to Section 3(14) of ERISA.

**Note G. Plan Termination**

Although the Company has not expressed any intent, the Company has the right under the Plan to discontinue, amend or modify and terminate the Plan without any liability for such termination subject to the provisions of ERISA. In the event of a Plan termination, participants would become 100% vested in any unvested portion of their accounts.

**Note H. Income Tax Status**

The Plan has adopted a volume submitter plan sponsored by Massachusetts Mutual Life Insurance Company. The volume submitter plan provider has received an advisory letter from the Internal Revenue Service as to the volume submitter plan's qualified status. The volume submitter plan advisory letter has been relied upon by the Plan. The Plan has been amended since the volume submitter plan received the advisory letter. The Plan Administrator believes the Plan is designed and is being operated in compliance with the applicable provisions of the Internal Revenue Code.

GAAP requires 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 is not likely to be sustained upon examination by the taxing authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

**Note I. Risks and Uncertainties**

The Plan invests in various investment securities. Investment securities are exposed to 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 amounts reported in the statements of net assets available for benefits.

**Note J. Subsequent Events**

The Plan Administrator has evaluated subsequent events through October 11, 2021, the date the financial statements were available to be issued.

Subsequent to year end, the Plan was amended and restated to bring the Plan into compliance with the legislative and regulatory changes set forth in Internal Revenue Service Notice 2017-37 (6 year pre-approved restatement cycle).

Effective January 1, 2022, the Plan was amended to include Roth deferrals as a permitted contribution type.

## **Supplemental Schedule**

**V. Sangiacomo & Sons 401(k) Plan****Plan Sponsor: EIN 94-1162486****Plan Number: 001****Schedule H, line 4i – Schedule of Assets (Held at End of Year)****December 31, 2021**

| (a)                                                    | (b)                                                                                                     | (c)  | (d)           | (e)       |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------|---------------|-----------|
| Identity of issuer, borrower, lessor, or similar party | Description of investment including maturity date, rate of interest, collateral, par, or maturity value | Cost | Current value |           |
| Vanguard                                               | Instl Target Ret 2040                                                                                   | **   | \$            | 7,023,408 |
| Vanguard                                               | Instl Target Ret 2030                                                                                   | **   |               | 1,558,617 |
| Vanguard                                               | Instl Target Ret 2035                                                                                   | **   |               | 599,375   |
| MFS                                                    | Growth Fund                                                                                             | **   |               | 307,469   |
| Fidelity                                               | 500 Index Fund                                                                                          | **   |               | 348,729   |
| Vanguard                                               | Instl Target Ret 2045                                                                                   | **   |               | 307,597   |
| Vanguard                                               | Instl Target Ret Inc                                                                                    | **   |               | 263,216   |
| * MassMutual                                           | SuperFlex Guaranteed                                                                                    | **   |               | 253,461   |
| Vanguard                                               | Instl Target Ret 2020                                                                                   | **   |               | 225,588   |
| BlackRock                                              | Total Return Fund                                                                                       | **   |               | 160,212   |
| JP Morgan                                              | Equity Income Fund                                                                                      | **   |               | 153,445   |
| Vanguard                                               | Instl Target Ret 2050                                                                                   | **   |               | 117,292   |
| Vanguard                                               | Instl Target Ret 2055                                                                                   | **   |               | 100,515   |
| Vanguard                                               | Mid Cap Index Fund                                                                                      | **   |               | 99,592    |
| * MassMutual                                           | Overseas Fund                                                                                           | **   |               | 94,147    |
| Vanguard                                               | Small-Cap Index Fund                                                                                    | **   |               | 91,057    |
| Invesco                                                | Global Fund                                                                                             | **   |               | 84,640    |
| Vanguard                                               | Instl Target Ret 2025                                                                                   | **   |               | 69,362    |
| T. Rowe Price                                          | Mid-Cap Growth Fund                                                                                     | **   |               | 37,650    |
| Janus Henderson                                        | Triton Fund                                                                                             | **   |               | 36,320    |
| Goldman Sachs                                          | Small-Cap Value Fund                                                                                    | **   |               | 21,181    |
| Allspring                                              | Special Mid-Cap Value Fund                                                                              | **   |               | 5,078     |
| Vanguard                                               | Instl Target Ret 2015                                                                                   | **   |               | 4,762     |
| Wells Fargo                                            | Stable Return Fund                                                                                      | **   |               | 759       |
| American Funds                                         | Balanced Fund                                                                                           | **   |               | 5         |

**\$ 11,963,477**

\* Indicates a party-in-interest as defined by ERISA.

\*\* Information not required as investments are participant-directed.

The above information has been certified by Reliance Trust Company

|                                                                                                  |                                                             |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A Name of Plan</b><br><b>V. Sangiacomo &amp; Sons 401(k) Plan</b>                             | <b>B Three-digit plan Number</b> <b>001</b>                 |
| <b>C Plan sponsor's name as shown on line 2a of Form 5500</b><br><b>V. Sangiacomo &amp; Sons</b> | <b>D Employer Identification Number</b><br><b>941162486</b> |

### Schedule H, line 4i - Schedule of Assets (Held At End of Year)

| (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 |
|-----|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------|-------------------|
| *   | MassMutual                                                | Guaranteed Interest Account                                                                                 | 253,461   | 253,461           |
| *   | Wells Fargo                                               | Allspring Special Mid Cap Val Fd                                                                            | 0         | 0                 |
| *   | Wells Fargo                                               | Allspring Special Mid Cap Val Fd                                                                            | 5,141     | 5,078             |
| *   | American Funds                                            | Amer Funds Balanced Fund                                                                                    | 3         | 5                 |
| *   | BlackRock                                                 | BlackRock Total Return Fund                                                                                 | 0         | 0                 |
| *   | BlackRock                                                 | BlackRock Total Return Fund                                                                                 | 161,278   | 160,212           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2015                                                                         | 4,794     | 4,762             |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2020                                                                         | 221,537   | 225,588           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2025                                                                         | 66,706    | 69,362            |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2030                                                                         | 1,477,960 | 1,558,615         |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2035                                                                         | 563,605   | 599,375           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2040                                                                         | 6,523,363 | 7,023,408         |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2045                                                                         | 286,345   | 307,597           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2050                                                                         | 108,849   | 117,292           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target R 2055                                                                         | 94,664    | 100,515           |
| *   | Vanguard                                                  | Closed Vanguard Instl Target RetInc                                                                         | 259,988   | 263,216           |
| *   | Fidelity Investments                                      | Fidelity 500 Index Fund                                                                                     | 226,869   | 348,729           |
| *   | Goldman Sachs                                             | Goldman Sachs Small Cap Value Fund                                                                          | 0         | 0                 |
| *   | Goldman Sachs                                             | Goldman Sachs Small Cap Value Fund                                                                          | 23,990    | 21,181            |
| *   | Invesco                                                   | Invesco Global Fund                                                                                         | 61,027    | 84,640            |
| *   | Janus Henderson                                           | Janus Henderson Triton Fd                                                                                   | 0         | 0                 |
| *   | Janus Henderson                                           | Janus Henderson Triton Fd                                                                                   | 41,421    | 36,320            |
| *   | JP Morgan                                                 | JP Morgan Equity Income Fund                                                                                | 118,776   | 153,445           |
| *   | MassMutual Select                                         | MassMutual Overseas Fund                                                                                    | 0         | 0                 |
| *   | MassMutual Select                                         | MassMutual Overseas Fund                                                                                    | 99,201    | 94,147            |
| *   | MassMutual Premier                                        | Holding Account - MassMutual US Gov                                                                         | 0         | 2                 |
| *   | MFS Investment Management                                 | MFS Growth Fund                                                                                             | 147,141   | 307,469           |
| *   | T. Rowe Price                                             | T. Rowe Price Mid-Cap Growth Fund                                                                           | 0         | 0                 |
| *   | T. Rowe Price                                             | T. Rowe Price Mid-Cap Growth Fund                                                                           | 38,793    | 37,650            |
| *   | Vanguard                                                  | Vanguard Mid Cap Index Fund                                                                                 | 69,554    | 99,592            |
| *   | Vanguard                                                  | Vanguard Small Cap Index Fund                                                                               | 50,895    | 91,057            |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2015 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2020 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2025 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2030 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2035 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2040 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2045 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2050 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2055 Fd                                                                              | 0         | 0                 |
| *   | Vanguard                                                  | Vanguard Target Retmnt Incm Fd                                                                              | 0         | 0                 |



|                                                                                                  |                                                             |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A Name of Plan</b><br><b>V. Sangiacomo &amp; Sons 401(k) Plan</b>                             | <b>B Three-digit Plan Number</b> <b>001</b>                 |
| <b>C Plan sponsor's name as shown on line 2a of Form 5500</b><br><b>V. Sangiacomo &amp; Sons</b> | <b>D Employee Identification Number</b><br><b>941162486</b> |

### Schedule H, line 4j - Schedule of Reportable Transactions

| (a) Identity of party involved | (b) Description of asset (include interest rate and maturity in case of a loan) | (c) Purchase price | (d) Selling price | (e) Lease Rental | (f) Expense incurred with transaction | (g) Cost of asset | (h) Current value of asset on transaction date | (i) Net gain or (loss) |
|--------------------------------|---------------------------------------------------------------------------------|--------------------|-------------------|------------------|---------------------------------------|-------------------|------------------------------------------------|------------------------|
| Vanguard                       | Vanguard Target Retmnt 2030 Fd                                                  | 0                  | 1,354,886         |                  | 0                                     | 944,321           | 1,354,886                                      | 410,565                |
| Vanguard                       | Vanguard Target Retmnt 2040 Fd                                                  | 0                  | 6,545,635         |                  | 0                                     | 3,457,405         | 6,545,635                                      | 3,088,230              |
| Vanguard                       | Closed Vanguard Instl Target R 2030                                             | 1,354,886          | 0                 |                  | 0                                     | 0                 | 0                                              | 0                      |
| Vanguard                       | Closed Vanguard Instl Target R 2040                                             | 6,545,635          | 0                 |                  | 0                                     | 0                 | 0                                              | 0                      |

## Schedule C Soft Dollar Compensation Eligible Indirect Compensation Statement

Mutual fund investments of the plan (whether direct or indirect through a separate investment account) may have soft dollar arrangements pursuant to which the investment advisor or sub-advisor to the mutual fund (and/or its affiliates) may direct trades to certain brokers in exchange for research and other services, other than just trade execution. For plans investing directly or indirectly in the MassMutual Premier or Select Funds, MassMutual provided the required written disclosure regarding soft dollar compensation on the Schedule C Formula Description and/or EIC Statement Description Attachment. For all other mutual funds, MassMutual provided the required written disclosure in the Statement of Additional Information (“SAI”).

For additional information on soft dollar compensation, refer to the section of the mutual fund’s SAI that discusses brokerage allocation and other practices.

|                                                                                                  |                                                             |            |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------|
| <b>A Name of Plan</b><br><b>V. Sangiacomo &amp; Sons 401(k) Plan</b>                             | <b>B Three-digit plan Number</b>                            | <b>001</b> |
| <b>C Plan sponsor's name as shown on line 2a of Form 5500</b><br><b>V. Sangiacomo &amp; Sons</b> | <b>D Employer Identification Number</b><br><b>941162486</b> |            |

### Schedule C Formula Description and/or EIC Statement Description

| Service Provider Name                       | Service Provider EIN | Service Provider Address | Formula / EIC Statement                                                                                                                                                                                                                                              |
|---------------------------------------------|----------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allspring                                   | 846615098            |                          | Allspring received estimated Investment Management Fees of 0.66% with respect to plan assets held in the Allspring Special Mid Cap Val Fd (MR-VR).                                                                                                                   |
| Allspring                                   | 846615098            |                          | Allspring received estimated Investment Management Fees of 0.66% with respect to plan assets held in the Allspring Special Mid Cap Val Fd (MR-228).                                                                                                                  |
| American Funds                              | 946050854            |                          | American Funds received estimated Investment Management Fees of 0.21% with respect to plan assets held in the Amer Funds Balanced Fund (MR-KM).                                                                                                                      |
| BlackRock                                   | 132949519            |                          | BlackRock received estimated Investment Management Fees of 0.35% with respect to plan assets held in the BlackRock Total Return Fund (MR-479).                                                                                                                       |
| BlackRock                                   | 132949519            |                          | BlackRock received estimated Investment Management Fees of 0.35% with respect to plan assets held in the BlackRock Total Return Fund (MR-1834).                                                                                                                      |
| Fidelity Investments                        | 043365630            |                          | Fidelity Investments received estimated Investment Management Fees of 0.02% with respect to plan assets held in the Fidelity 500 Index Fund (MR-4401).                                                                                                               |
| Goldman Sachs                               | 134166989            |                          | Goldman Sachs received estimated Investment Management Fees of 0.92% with respect to plan assets held in the Goldman Sachs Small Cap Value Fund (MR-631).                                                                                                            |
| Goldman Sachs                               | 134166989            |                          | Goldman Sachs received estimated Investment Management Fees of 0.92% with respect to plan assets held in the Goldman Sachs Small Cap Value Fund (MR-3309).                                                                                                           |
| Great West Life & Annuity Insurance Company | 840467907            |                          | Millennium Trust Company, LLC paid Empower a one-time referral fee of \$50 for each participant IRA rollover with a balance of \$10,000 or more, \$40 with a balance of \$500 or more but less than \$10,000, and \$20 with a balance of \$150 or more but less than |
| Invesco                                     | 132649093            |                          | Invesco received estimated Investment Management Fees of 0.63% with respect to plan assets held in the Invesco Global Fund (MR-ND).                                                                                                                                  |
| Janus Henderson                             | 840592523            |                          | Janus Henderson received estimated Investment Management Fees of 0.64% with respect to plan assets held in the Janus Henderson Triton Fd (MR-1186).                                                                                                                  |
| Janus Henderson                             | 840592523            |                          | Janus Henderson received estimated Investment Management Fees of 0.64% with respect to plan assets held in the Janus Henderson Triton Fd (MR-1363).                                                                                                                  |
| JP Morgan                                   | 263613641            |                          | JP Morgan received estimated Investment Management Fees of 0.40% with respect to plan assets held in the JP Morgan Equity Income Fund (MR-1805).                                                                                                                     |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual provided the Plan with the required written disclosure for float revenue received by MassMutual.                                                                                                                                                          |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.15% with respect to plan assets held in the MFS Growth Fund (MR-1274).                                                                                                                                                |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.30% with respect to plan assets held in the Invesco Global Fund (MR-ND).                                                                                                                                              |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.05% with respect to plan assets held in the Amer Funds Balanced Fund (MR-KM).                                                                                                                                         |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.10% with respect to plan assets held in the Janus Henderson Triton Fd (MR-1363).                                                                                                                                      |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.25% with respect to plan assets held in the Janus Henderson Triton Fd (MR-1186).                                                                                                                                      |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.20% with respect to plan assets held in the BlackRock Total Return Fund (MR-479).                                                                                                                                     |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Administrative Fees of 0.15% with respect to plan assets held in the MassMutual Overseas Fund (MR-SH).                                                                                                                                 |
| Massachusetts Mutual Life Insurance Company | 041590850            |                          | MassMutual received estimated Sub-TA Fees of 0.35% with respect to plan assets held in the Allspring Special Mid Cap Val Fd (MR-VR).                                                                                                                                 |

|                                             |           |                                                                                                                                                                             |
|---------------------------------------------|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Sub-TA Fees of 0.15% with respect to plan assets held in the Allspring Special Mid Cap Val Fd (MR-228).                                       |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Sub-TA Fees of 0.15% with respect to plan assets held in the T. Rowe Price Mid-Cap Growth Fund (MR-556).                                      |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Sub-TA Fees of 0.15% with respect to plan assets held in the Goldman Sachs Small Cap Value Fund (MR-631).                                     |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Investment Management Fees of 0.80% with respect to plan assets held in the MassMutual Overseas Fund (MR-IH).                                 |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Investment Management Fees of 0.80% with respect to plan assets held in the MassMutual Overseas Fund (MR-SH).                                 |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Administrative Fees of 0.10% with respect to plan assets held in the MassMutual US Government Mny Mkt Fd (MR-G).                              |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual received estimated Investment Management Fees of 0.35% with respect to plan assets held in the MassMutual US Government Mny Mkt Fd (MR-G).                       |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual provided the plan with the required written disclosure for soft dollar compensation received by the subadviser with respect to MassMutual Overseas Fund (MR-IH). |
| Massachusetts Mutual Life Insurance Company | 041590850 | MassMutual provided the plan with the required written disclosure for soft dollar compensation received by the subadviser with respect to MassMutual Overseas Fund (MR-SH). |
| MFS Investment Management                   | 043158862 | MFS Investment Management received estimated Investment Management Fees of 0.51% with respect to plan assets held in the MFS Growth Fund (MR-1274).                         |
| T. Rowe Price                               | 521784828 | T. Rowe Price received estimated Investment Management Fees of 0.61% with respect to plan assets held in the T. Rowe Price Mid-Cap Growth Fund (MR-556).                    |
| T. Rowe Price                               | 521784828 | T. Rowe Price received estimated Investment Management Fees of 0.61% with respect to plan assets held in the T. Rowe Price Mid-Cap Growth Fund (MR-3328).                   |
| Vanguard                                    | 231999755 | Vanguard received estimated Investment Management Fees of 0.04% with respect to plan assets held in the Vanguard Mid Cap Index Fund (MR-2070).                              |
| Vanguard                                    | 231999755 | Vanguard received estimated Investment Management Fees of 0.04% with respect to plan assets held in the Vanguard Small Cap Index Fund (MR-947).                             |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2015 Fd (MR-621).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2020 Fd (MR-622).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2025 Fd (MR-623).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2030 Fd (MR-624).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2035 Fd (MR-625).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2040 Fd (MR-626).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2045 Fd (MR-627).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2050 Fd (MR-628).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt Incm Fd (MR-618).                            |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.08% with respect to plan assets held in the Vanguard Target Retmnt 2055 Fd (MR-1283).                           |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2971).                           |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2973).                           |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2974).                           |
| Vanguard                                    | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2975).                           |

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|----------|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2976). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2977). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2978). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2979). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2980). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2981). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Target R (MR-2982). |
| Vanguard | 232311358 | Vanguard received estimated Investment Management Fees of 0.09% with respect to plan assets held in the Closed Vanguard Instl Trgt Ret (MR-3970). |