

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <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> |
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|                                                                                                          |                                                 |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <b>Part I</b>                                                                                            | <b>Annual Report Identification Information</b> |
| For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u> |                                                 |

**A** This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)

☒ a single-employer plan ☐ a DFE (specify) \_\_\_\_\_

**B** This return/report is: ☐ the first return/report ☐ the final return/report

☐ an amended return/report ☐ a short plan year return/report (less than 12 months)

**C** If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

**D** Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program

☐ special extension (enter description) \_\_\_\_\_

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                     |            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------|
| <b>Part II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Basic Plan Information</b> —enter all requested information      |            |
| <b>1a</b> Name of plan<br><u>NIXON POWER SERVICES 401(K) PLAN</u><br><br><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>NIXON POWER SERVICES</u><br><br><u>155 FRANKLIN ROAD</u><br><u>SUITE 255</u><br><u>BRENTWOOD, TN 37027</u> | <b>1b</b> Three-digit plan number (PN) ▶                            | <u>001</u> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c</b> Effective date of plan<br><u>01/01/1992</u>               |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>2b</b> Employer Identification Number (EIN)<br><u>42-1608629</u> |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>2c</b> Plan Sponsor's telephone number<br><u>615-309-5824</u>    |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>2d</b> Business code (see instructions)<br><u>551112</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. | 10/17/2022 | DONNA COOPER                                                 |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/17/2022 | DONNA COOPER                                                 |
|                  | 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.

Form 5500 (2021)  
v. 210624

|                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| <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><b>4d</b> PN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |     |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                            |  | <b>5</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 256 |
| <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 222 |
| <b>a(2)</b> Total number of active participants at the end of the plan year .....                                                                                                                                                                                                                                                                                                                                  |  | <b>6a(2)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 217 |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                                                                                                                                                                                                                                                                                 |  | <b>6b</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1   |
| <b>c</b> Other retired or separated participants entitled to future benefits .....                                                                                                                                                                                                                                                                                                                                 |  | <b>6c</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 41  |
| <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....                                                                                                                                                                                                                                                                                                                                        |  | <b>6d</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 259 |
| <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 259 |
| <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 250 |
| <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16  |
| <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 2S 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>(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<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 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>NIXON POWER SERVICES 401(K) PLAN                                         | B Three-digit plan number (PN) ▶ 001                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>NIXON POWER SERVICES             | D Employer Identification Number (EIN)<br>42-1608629 |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 62112                              | 259                                                                         | 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 |                       |
|                                               |                                 |             |                       |

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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 |                                 |
|                                                      |                                 |                    |                                 |

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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 |                                 |
|                                                      |                                 |                    |                                 |

---

**(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>2483727</b> |
|----------|-----------------------------------------------|-----------|----------------|

|          |                                                              |              |               |  |
|----------|--------------------------------------------------------------|--------------|---------------|--|
| <b>c</b> | Additions: (1) Contributions deposited during the year ..... | <b>7c(1)</b> | <b>100127</b> |  |
|          | (2) Dividends and credits.....                               | <b>7c(2)</b> | <b>0</b>      |  |
|          | (3) Interest credited during the year.....                   | <b>7c(3)</b> | <b>56976</b>  |  |
|          | (4) Transferred from separate account.....                   | <b>7c(4)</b> | <b>0</b>      |  |
|          | (5) Other (specify below) .....                              | <b>7c(5)</b> | <b>4408</b>   |  |

▶ **LN INT, LN PRIN, LOAN DEFAULT, LOAN**

|                          |              |               |
|--------------------------|--------------|---------------|
| (6)Total additions ..... | <b>7c(6)</b> | <b>161511</b> |
|--------------------------|--------------|---------------|

|          |                                                                              |           |                |
|----------|------------------------------------------------------------------------------|-----------|----------------|
| <b>d</b> | Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) ..... | <b>7d</b> | <b>2645238</b> |
|----------|------------------------------------------------------------------------------|-----------|----------------|

|          |                                                                           |              |               |  |
|----------|---------------------------------------------------------------------------|--------------|---------------|--|
| <b>e</b> | Deductions:                                                               |              |               |  |
|          | (1) Disbursed from fund to pay benefits or purchase annuities during year | <b>7e(1)</b> | <b>132317</b> |  |
|          | (2) Administration charge made by carrier.....                            | <b>7e(2)</b> | <b>13301</b>  |  |
|          | (3) Transferred to separate account.....                                  | <b>7e(3)</b> | <b>36330</b>  |  |
|          | (4) Other (specify below) .....                                           | <b>7e(4)</b> | <b>679</b>    |  |

▶ **LN DISTRIB**

|                            |              |               |
|----------------------------|--------------|---------------|
| (5) Total deductions ..... | <b>7e(5)</b> | <b>182627</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>2462611</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>NIXON POWER SERVICES 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>NIXON POWER SERVICES      | <b>D</b> Employer Identification Number (EIN)<br>42-1608629 |     |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <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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**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 72      | CONTRACT ADMINISTRATOR                                                                            | 66817                                                                  | 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)

RESOURCES INVESTMENT ADVISORS INC.

43-1451524

| (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"/>                                                            | 29630                                                                                                                                                                           | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

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

ALLSPRING

41-0449260

| (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)

AMERICAN CENTURY

43-1646043

| (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)

ARTISAN

39-1811840

| (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)

BLACKROCK

51-0318674

| (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? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 49                     | RECORDKEEPER                                                                                      | 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)

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)

METROPOLITAN WEST ASSET MANAGEMENT

95-4597302

| (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)

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)

NEXTCAPITAL ADVISERS, INC.

47-2342699

| (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 ADVISER                                                                                | 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

23-1945930

| (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

23-1999755

| (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)

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)

VICTORY

31-6364605

| (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)

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"/>                          |

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

| (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? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input 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)

| (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? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                        |                                                                                                   |                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                             | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input 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 |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INS. CO.                                  | 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. |                                           |
| SAGIC CORE BOND II 62112<br><br>04-1590850                          | 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.                                  | 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 INTL DIVERSIFICATION FD<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                                                                                                                                         |                                           |

**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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INS. CO.                      | 60                                      | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VICTORY INTEGRITY SMALL-CAP VAL FD<br><br>31-6364605                | 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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INS. CO.                      | 60                                      | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ALLSPRING SMALL COMPANY GROWTH<br>FD<br><br>41-0449260              | 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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INS. CO.                      | 60                                      | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| METROPOLITAN WEST TOTAL RTRN BND<br>FD<br><br>95-4597302            | 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 |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| RESOURCES INVESTMENT ADVISORS INC.                      | 27                                      | 29630                                     |

| (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 SMALL COMPANY GROWTH<br>FD<br><br>41-0449260              | 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 |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| AMERICAN CENTURY                                        | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AMERICAN CENTURY SMALL CAP VALUE<br>FD<br><br>43-1646043            | 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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| ARTISAN                                                 | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ARTISAN INTERNATIONAL VALUE FUND<br><br>39-1811840                  | 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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| BLACKROCK                                               | 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BLACKROCK MID-CAP GROWTH EQUITY<br>FD<br><br>51-0318674             | 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 |
|---------------------------------------------------------|-----------------------------------------|----------------------------------------------|
| 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<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MILLENNIUM TRUST COMPANY, LLC<br><br>36-4400066                     | REFERRAL FEE                                                                                                                                                             |

**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 |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| 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 LARGE CAP GROWTH 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 |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| METROPOLITAN WEST ASSET 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. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| METROPOLITAN WEST TOTAL RTRN BND<br>FD<br><br>95-4597302            | 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 INTL DIVERSIFICATION FD<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 |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 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 MID CAP VALUE 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 |
| NEXTCAPITAL ADVISERS, INC.                                          | 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. |                                           |
| GREAT WEST LIFE & ANNUITY INSURANCE<br><br>84-0467907               | 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 DEVELOPED MARKETS INDEX FD<br><br>23-1945930               | 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 EMERG MRKTS STOCK INDX<br>FD<br><br>23-1945930             | 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 EQUITY-INCOME FUND<br><br>23-1945930                       | 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 REAL ESTATE INDEX FUND<br><br>23-1945930                   | 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 TOTAL BOND MRKT INDEX FUND<br><br>23-1945930               | 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 500 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 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 MID CAP INDEX FUND<br><br>23-1999755                       | 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 SMALL 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 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                                                                                                                                         |                                           |

**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 2025 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 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                                                                                                                                         |                                           |

**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 2040 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 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                                                                                                                                         |                                           |

**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 2055 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 2060 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 INCM 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 |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| VICTORY                                                             | 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. |                                           |
| VICTORY INTEGRITY SMALL-CAP VAL FD<br><br>31-6364605                | 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 |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|                                                                     |                                                                                                                                                                    |                                           |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
|                                                                     |                                                                                                                                                                    |                                           |

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

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

|                    |                     |
|--------------------|---------------------|
| <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:

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                              |                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <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>NIXON POWER SERVICES 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>NIXON POWER SERVICES</b>             | <b>D</b> Employer Identification Number (EIN)<br><b>42-1608629</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>    |                       |                 |
| <b>(2)</b> Participant contributions.....                                                         | <b>1b(2)</b>    |                       |                 |
| <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>    | 170247                | 99596           |
| <b>(9)</b> Value of interest in common/collective trusts .....                                    | <b>1c(9)</b>    | 0                     | 0               |
| <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>   | 8625625               | 10382147        |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)..... | <b>1c(14)</b>   | 2483727               | 2462611         |
| <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 11279599           | 12944354        |
| <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 11279599           | 12944354        |

**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>Income</b> |                                                                                                     |                  |           |
| <b>a</b>      | <b>Contributions:</b>                                                                               |                  |           |
| (1)           | Received or receivable in cash from: <b>(A)</b> Employers .....                                     | 2a(1)(A) 175666  |           |
|               | <b>(B)</b> Participants .....                                                                       | 2a(1)(B) 1050008 |           |
|               | <b>(C)</b> Others (including rollovers).....                                                        | 2a(1)(C) 58469   |           |
| (2)           | Noncash contributions.....                                                                          | 2a(2)            |           |
| (3)           | Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2) .....                             | 2a(3)            | 1284143   |
| <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) 6245    |           |
|               | <b>(F)</b> Other .....                                                                              | 2b(1)(F) 56976   |           |
|               | <b>(G)</b> Total interest. Add lines 2b(1)(A) through (F).....                                      | 2b(1)(G)         | 63221     |
| (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) 1020286 |           |
|               | <b>(D)</b> Total dividends. Add lines 2b(2)(A), (B), and (C) .....                                  | 2b(2)(D)         | 1020286   |
| (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)  |            | 0         |
| (7) Net investment gain (loss) from pooled separate accounts.....                              | 2b(7)  |            | 0         |
| (8) Net investment gain (loss) from master trust investment accounts.....                      | 2b(8)  |            |           |
| (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) |            | 374231    |
| c Other income.....                                                                            | 2c     |            | 0         |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total.....               | 2d     |            | 2741881   |
| <b>Expenses</b>                                                                                |        |            |           |
| e Benefit payment and payments to provide benefits:                                            |        |            |           |
| (1) Directly to participants or beneficiaries, including direct rollovers.....                 | 2e(1)  | 1010097    |           |
| (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)  |            | 1010097   |
| f Corrective distributions (see instructions).....                                             | 2f     |            | 212       |
| g Certain deemed distributions of participant loans (see instructions).....                    | 2g     |            | 0         |
| h Interest expense.....                                                                        | 2h     |            |           |
| i Administrative expenses: (1) Professional fees.....                                          | 2i(1)  | 0          |           |
| (2) Contract administrator fees.....                                                           | 2i(2)  | 2770       |           |
| (3) Investment advisory and management fees.....                                               | 2i(3)  | 61607      |           |
| (4) Other.....                                                                                 | 2i(4)  | 2440       |           |
| (5) Total administrative expenses. Add lines 2i(1) through (4).....                            | 2i(5)  |            | 66817     |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....            | 2j     |            | 1077126   |
| <b>Net Income and Reconciliation</b>                                                           |        |            |           |
| k Net income (loss). Subtract line 2j from line 2d.....                                        | 2k     |            | 1664755   |
| 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: LPMC PC

(2) EIN: 62-1199757

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                   |                    | 500000 |
| <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.) .....                                                                                                                                                                    |                     |                    |        |
| <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? .....                                                                                                                                                                                                                             |                     |                    |        |
| <b>4k</b>                                                                                                                                                                                                                                                                                                                                                                                       |                     | X                  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                                                                                                              |                     |                    |        |
| <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.) .....                                                                                                                                                                                                                                                                    |                     |                    |        |
| <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>                                                                                                                                                                                                                                                                                                                                                                                       |                     |                    |        |
| <b>5a</b> Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.                                                                                                             |                     |                    |        |
| <b>5b</b> 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.)                                                                                                                                                                                    |                     |                    |        |
| <b>5b(1)</b> Name of plan(s)                                                                                                                                                                                                                                                                                                                                                                    | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> PN(s) |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                    |        |
| <b>5c</b> 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.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined<br>If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____. |                     |                    |        |

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>SCHEDULE R</b><br><b>(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>Retirement Plan Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110<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 01/01/2021 and ending 12/31/2021

|                                                                                              |                                                                    |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><u>NIXON POWER SERVICES 401(K) PLAN</u>                             | <b>B</b> Three-digit plan number (PN) ▶<br><u>001</u>              |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>NIXON POWER SERVICES</u> | <b>D</b> Employer Identification Number (EIN)<br><u>42-1608629</u> |

|               |                      |
|---------------|----------------------|
| <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> | <u>0</u> |
| <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): <u>04-1590850</u> |          |          |
| 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 \_\_\_\_\_

**NIXON POWER SERVICES 401(K) PLAN**

**Financial Statements and Supplemental Schedule**

**December 31, 2021 and 2020**

**(With Independent Auditors' Report Thereon)**

# **NIXON POWER SERVICES 401(K) PLAN**

## **Table of Contents**

|                                                                       | <b><u>Page</u></b> |
|-----------------------------------------------------------------------|--------------------|
| <b>Independent Auditors' Report</b>                                   | <b>1 - 4</b>       |
| <b>Financial Statements:</b>                                          |                    |
| <b>Statements of Net Assets Available for Benefits</b>                | <b>5</b>           |
| <b>Statements of Changes in Net Assets Available for Benefits</b>     | <b>6</b>           |
| <b>Notes to the Financial Statements</b>                              | <b>7 - 14</b>      |
| <b>Supplemental Schedule:</b>                                         |                    |
| <b>Schedule H, Line 4i - Schedule of Assets (Held at End of Year)</b> | <b>15</b>          |

## Independent Auditors' Report

The Plan Administrator  
Nixon Power Services 401(k) Plan:

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

We have performed an audit of the financial statements of the Nixon Power Services 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 statement of net assets available for benefits as of December 31, 2021, and the related statement of changes in net assets available for benefits for the year then ended and the related notes to the financial statements ("2021 Financial Statements").

Management, having determined it is permissible in the circumstances, has elected to have the audit of the Plan's 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 certifications from qualified institutions as of and for the year ended December 31, 2021, stating that the certified investment information, as described in Note 3 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 *Auditors' Responsibilities for the Audit of the 2021 Financial Statements* section of our report,

- 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 ("GAAP").
- the information in the accompanying 2021 financial statements related to assets held by and certified to by qualified institutions agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management has determined meets the requirements of ERISA Section 103(a)(3)(C).

### ***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 *Auditors' 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 2021 financial statements in accordance with 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 2021 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 2021 financial statements are issued or are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the 2021 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.

### ***Auditors' 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 for the 2021 Financial Statements* section of our report, our objectives are to obtain reasonable assurance about whether the 2021 financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' 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 substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the 2021 financial statements.

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 2021 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 certifications, 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 GAAP.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the 2021 financial statements as a whole are presented fairly, in all material respects, in accordance with 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 Matter - 2021 Supplemental Schedule Required by ERISA***

The supplemental schedule of assets (held at end of year) as of December 31, 2021 is presented for the purposes of additional analysis and is not a required part of the 2021 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 2021 financial statements. 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 2021 financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2021 financial statements or to the 2021 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, is 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 qualified institutions 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).

*Other Matter - Auditors' 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 the 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 qualified institutions. In our report dated October 5, 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 information certified by qualified institutions were presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

*LBM, PC*

Brentwood, Tennessee  
October 14, 2022

**NIXON POWER SERVICES 401(K) PLAN**

**Statements of Net Assets Available for Benefits**

**December 31, 2021 and 2020**

|                                    | <u><b>2021</b></u>   | <u><b>2020</b></u>   |
|------------------------------------|----------------------|----------------------|
| <b>Assets:</b>                     |                      |                      |
| Investments, at fair value         | \$ 10,382,147        | \$ 8,625,625         |
| Investments, at contract value     | <u>2,462,611</u>     | <u>2,483,727</u>     |
| Total investments                  | <u>12,844,758</u>    | <u>11,109,352</u>    |
| <b>Receivables:</b>                |                      |                      |
| Plan sponsor contributions         | 253,157              | 171,328              |
| Participant contributions          | 32,287               | 30,056               |
| Notes receivable from participants | <u>99,596</u>        | <u>170,247</u>       |
| Total receivables                  | <u>385,040</u>       | <u>371,631</u>       |
| Net assets available for benefits  | <u>\$ 13,229,798</u> | <u>\$ 11,480,983</u> |

See accompanying notes to the financial statements.

**NIXON POWER SERVICES 401(K) PLAN**

**Statements of Changes in Net Assets Available for Benefits**

**Years ended December 31, 2021 and 2020**

|                                                        | <u><b>2021</b></u>   | <u><b>2020</b></u>   |
|--------------------------------------------------------|----------------------|----------------------|
| <b>Additions to net assets attributed to:</b>          |                      |                      |
| Net appreciation in fair value of investments          | \$ 1,394,516         | \$ 1,988,962         |
| Interest and dividend income                           | <u>56,976</u>        | <u>60,672</u>        |
| Net change resulting from investment activity          | <u>1,451,492</u>     | <u>2,049,634</u>     |
| Interest income on notes receivable from participants  | <u>6,245</u>         | <u>9,086</u>         |
| <b>Contributions:</b>                                  |                      |                      |
| Plan sponsor                                           | 257,497              | 171,330              |
| Participants                                           | 1,052,239            | 1,021,224            |
| Participant rollovers                                  | <u>58,469</u>        | <u>76,805</u>        |
| Total contributions                                    | <u>1,368,205</u>     | <u>1,269,359</u>     |
| Net additions                                          | <u>2,825,942</u>     | <u>3,328,079</u>     |
| <b>Deductions from net assets attributed to:</b>       |                      |                      |
| Benefits paid                                          | 1,010,309            | 3,369,339            |
| Administrative expenses                                | <u>66,818</u>        | <u>66,786</u>        |
| Total deductions                                       | <u>1,077,127</u>     | <u>3,436,125</u>     |
| Net increase (decrease)                                | 1,748,815            | (108,046)            |
| Net assets available for benefits at beginning of year | <u>11,480,983</u>    | <u>11,589,029</u>    |
| Net assets available for benefits at end of year       | \$ <u>13,229,798</u> | \$ <u>11,480,983</u> |

See accompanying notes to the financial statements.

# **NIXON POWER SERVICES 401(K) PLAN**

## **Notes to the Financial Statements**

**December 31, 2021 and 2020**

### **(1) Description of plan**

The following description of the Nixon Power Services 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.

#### **(a) General**

The Plan is a defined contribution plan which was adopted to provide retirement benefits for employees of Nixon Power Services, LLC (the "Plan Sponsor"). The Plan covers substantially all employees that have completed six months of service and are age 18 or older ("participants"). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

#### **(b) Contributions**

New participants are automatically enrolled in the Plan upon meeting the eligibility provisions. Unless the participant elects another deferral percentage or chooses not to participate, participants will defer 3% of compensation. The percentage will increase each year by 1%, on April 1, up to a maximum of 10%. The participant may elect not to automatically increase their deferral percentage. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans.

The Plan Sponsor may make a discretionary matching contribution each year. Participants must be employed on the last day of the plan year and have completed at least 1,000 hours of service during the year, unless the participant dies, becomes disabled or retires during the year. During 2021, the Plan Sponsor elected to match 35% of participant contributions up to 6%. For 2020, the Plan Sponsor elected to match 25% of participant contributions up to 6%. Plan Sponsor and participant contributions may not exceed the maximum amount deductible for federal income tax purposes.

The Plan Sponsor may make an additional discretionary contribution each year. Participants must be employed on the last day of the plan year and have completed at least 1,000 hours of service during the year, unless the participant dies, becomes disabled or retires during the year. The Plan Sponsor contribution is allocated to eligible participants based on a uniform percentage of the participants compensation, as defined in the plan document. There were no additional discretionary contributions in 2021 or 2020.

# **NIXON POWER SERVICES 401(K) PLAN**

## **Notes to the Financial Statements**

**December 31, 2021 and 2020**

**(c) Participant accounts**

Each participant's account is credited or charged with the participant's and Plan Sponsor contributions and allocations of investment earnings (losses) and administrative expenses. Allocations are based on participant compensation or account balances as defined in the plan agreement. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Participants direct the investment of their accounts into various investment options offered by the Plan. The Plan currently offers mutual funds and a guaranteed investment contract.

**(d) Vesting**

Participants are immediately vested in their elective salary deferral and any Plan Sponsor additional discretionary contribution. Vesting in the Plan Sponsor's discretionary matching contribution is based on years of continuous service. Participants vest according to the following schedule:

| <u>Years of<br/>Continuous<br/>Service</u> | <u>Vesting<br/>Percentage</u> |
|--------------------------------------------|-------------------------------|
| Less than 2                                | 0 %                           |
| 2                                          | 25 %                          |
| 3                                          | 50 %                          |
| 4                                          | 75 %                          |
| 5                                          | 100 %                         |

**(e) Notes receivable from participants**

Each participant may borrow from his or her fund accounts a minimum of \$500 up to the lesser of \$50,000 or 50% of his or her vested account balance. The notes are secured by the balances in the respective participants' accounts and bear interest at a fixed rate of the prime rate plus 1% (4.25% - 6.50% at December 31, 2021). Principal and interest are paid ratably through payroll deductions.

**(f) Payment of benefits**

On termination of service due to death, permanent disability, or retirement, a participant may take a distribution of his or her entire account balance in a single lump sum or elect to receive annual installments over a specified period. For termination of service due to other reasons, a participant will be entitled to receive only the vested interest in his or her account.

# **NIXON POWER SERVICES 401(K) PLAN**

## **Notes to the Financial Statements**

**December 31, 2021 and 2020**

**(g) Forfeited accounts**

Forfeitures are created when participants terminate employment prior to becoming fully vested in the Plan Sponsor discretionary matching contribution portion of their accounts. Forfeited amounts are used to offset Plan Sponsor contributions under the Plan for the Plan year in which the forfeiture occurs. Forfeitures may also be used to reduce Plan expenses. As of December 31, 2021 and 2020, forfeited nonvested accounts totaled \$23,230 and \$16,571. No forfeitures were used in 2021 or 2020.

**(h) Hardship withdrawals**

The Plan permits distributions in the event of a hardship, as defined in the plan agreement. These distributions are taxable and subject to a tax penalty equal to 10% of the hardship distribution amount if the participant is younger than age 59½. Amounts available for hardship withdrawals include earnings on all eligible sources and the participant's vested account balance.

**(i) Administrative expenses**

Certain expenses of maintaining the Plan are paid directly by the Plan Sponsor and are excluded from these financial statements. Fees related to investment advisory, processing of distributions and loan origination fees are included in administrative expenses and charged directly to the participant's account. Investment related expenses are included in net appreciation in fair value of investments.

**(j) Plan changes**

During 2020, the Plan has implemented certain provisions allowed by the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) and the Setting Every Community Up for Retirement Enhancement Act of 2019 (the SECURE Act), which changed the Plan to allow certain eligible individuals to receive coronavirus-related distributions of up to \$100,000, suspend required minimum distributions, and delayed the commencement date for required minimum distributions. Written amendments to the Plan to reflect these operational changes will be adopted at a later date in accordance with applicable law and IRS guidance.

**(k) Plan termination**

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

# **NIXON POWER SERVICES 401(K) PLAN**

## **Notes to the Financial Statements**

**December 31, 2021 and 2020**

### **(2) Summary of significant accounting policies**

#### **(a) Basis of accounting**

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

#### **(b) Investment valuation and income recognition**

The Plan's investments are reported at fair value (except for the investment contract, which is reported at contract value). Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. These investment values are discussed more fully in Notes 4 and 5.

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

#### **(c) Notes receivable from participants**

Notes receivable from participants are measured at their unpaid principal balances plus any accrued but unpaid interest. Delinquent notes receivable are reclassified as distributions based upon the terms of the plan document. Interest income is recorded on the accrual basis. No allowance for credit losses has been recorded as of December 31, 2021 and 2020.

#### **(d) Payment of benefits**

Benefits are recorded when paid.

#### **(e) Use of estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of net assets available for benefits and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

#### **(f) Events occurring after the reporting date**

The Plan Sponsor has evaluated events and transactions that occurred between December 31, 2021 and October 14, 2022, which is the date that the financial statements were available to be issued, for possible recognition or disclosure in the financial statements.

# NIXON POWER SERVICES 401(K) PLAN

## Notes to the Financial Statements

December 31, 2021 and 2020

### (3) Certified information

Information related to investments disclosed in the accompanying financial statements and supplemental schedule, including the fair value and contract value of investments and notes receivable from participants held at December 31, 2021 and 2020, was obtained or derived from information supplied to the plan administrator and certified as complete and accurate by Great-West Life & Annuity Insurance Company ("Great-West") and Reliance Trust Company ("Reliance Trust"). Net appreciation in fair value of investments, interest and dividend income, and interest income on notes receivable from participants was certified by Great-West and Reliance Trust for the year ended December 31, 2021 and Massachusetts Mutual Life Insurance Company ("MassMutual") and Reliance Trust for the year ended December 31, 2020. Effective December 31, 2020, Empower Retirement, LLC ("Empower") acquired MassMutual.

### (4) Fair value measurements

The Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 820, *Fair Value Measurements*, provides the framework for measuring fair value. That framework 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 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

**Level 1** - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

**Level 2** - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

**Level 3** - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

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

# NIXON POWER SERVICES 401(K) PLAN

## Notes to the Financial Statements

December 31, 2021 and 2020

The following is a description of the valuation methodology used for assets measured at fair value at December 31, 2021 and 2020:

- (i) *Mutual funds*: Valued based on the funds' reported closing net asset values of shares held by the Plan as of the last business day of the plan year. The mutual funds are deemed to be actively traded.

The method described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plan's management believes its valuation method is appropriate and consistent with other market participants, the use of a different methodology or assumption to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

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

### Fair Value Measurements as of December 31, 2021 using the following inputs

|              | <u>Level 1</u>       | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u>         |
|--------------|----------------------|----------------|----------------|----------------------|
| Mutual funds | \$ <u>10,382,147</u> | \$ <u>-</u>    | \$ <u>-</u>    | \$ <u>10,382,147</u> |

### Fair Value Measurements as of December 31, 2020 using the following inputs

|              | <u>Level 1</u>      | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u>        |
|--------------|---------------------|----------------|----------------|---------------------|
| Mutual funds | \$ <u>8,625,625</u> | \$ <u>-</u>    | \$ <u>-</u>    | \$ <u>8,625,625</u> |

#### (5) Investment contract with insurance company

The Plan entered into a fully benefit-responsive group annuity contract with Great-West (MassMutual in 2020) totaling \$2,462,611 and \$2,483,727 at December 31, 2021 and 2020, respectively. The insurance company maintains the Plan's contributions in a general account which is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. The crediting rate is based on a formula established by the contract issuer. The crediting rate is reviewed on a quarterly basis for resetting. The guaranteed investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

# NIXON POWER SERVICES 401(K) PLAN

## Notes to the Financial Statements

December 31, 2021 and 2020

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, as reported to the Plan by Great-West and MassMutual represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

The Plan's ability to receive amounts due is dependent on the 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 issuer. Such events include the following: (1) the complete or partial termination of the Plan; (2) the establishment or activation of, or material change in, any Plan investment fund, or an amendment to the Plan or a change in the administration or operation of the Plan, including the removal of a group of employees from Plan coverage as a result of the sale or liquidation of a subsidiary or division or as a result of group layoffs or early retirement programs. No events are 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.

### (6) Income tax status

The Plan Sponsor adopted a volume submitter plan, which received a favorable opinion letter from the Internal Revenue Service ("IRS") on March 31, 2014, which stated that the volume submitter plan was designed in accordance with the applicable sections of the IRC. The Plan itself has not received a determination letter from the IRS stating that the Plan is qualified under Section 401(a) of the IRC. However, the plan administrator believes that the Plan is designed, as amended, and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, qualified and exempt from taxation.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability or asset if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2021 and 2020, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or asset or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

# NIXON POWER SERVICES 401(K) PLAN

## Notes to the Financial Statements

December 31, 2021 and 2020

### (7) Reconciliation of financial statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2021 and 2020.

|                                                                | <u>2021</u>          | <u>2020</u>          |
|----------------------------------------------------------------|----------------------|----------------------|
| Net assets available for benefits per the financial statements | \$ 13,229,798        | \$ 11,480,983        |
| Plan Sponsor contributions receivable                          | (253,157)            | (171,328)            |
| Participant contributions receivable                           | (32,287)             | (30,056)             |
| Rounding                                                       | <u>2</u>             | <u>2</u>             |
| Net assets available for benefits per the Form 5500            | <u>\$ 12,944,356</u> | <u>\$ 11,279,601</u> |

The following is a reconciliation of the change in net assets available for benefits per the financial statements to the Form 5500 for the years ended December 31, 2021 and 2020.

|                                                                          | <u>2021</u>         | <u>2020</u>         |
|--------------------------------------------------------------------------|---------------------|---------------------|
| Change in net assets available for benefits per the financial statements | \$ 1,748,815        | \$ (108,046)        |
| Change in plan sponsor contributions receivable                          | (81,829)            | (48,236)            |
| Change in participant contributions receivable                           | <u>(2,231)</u>      | <u>(30,056)</u>     |
| Change in net assets available for benefits per the Form 5500            | <u>\$ 1,664,755</u> | <u>\$ (186,338)</u> |

### (8) Risks and uncertainties

The Plan utilizes various investment instruments. Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

### (9) Related party and party-in-interest transactions

Certain Plan investments are in an investment contract managed by Great-West and previously, MassMutual and, therefore, these transactions qualify as party-in-interest transactions under ERISA. As described in Note 1, the Plan paid expenses to various service providers and holds notes receivable from participants which also qualify as party-in-interest transactions.

# NIXON POWER SERVICES 401(K) PLAN

EIN 42-1608629, PLAN No. 001

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

December 31, 2021

| (a) | (b)                                                         | (c)                                                                                                                 | (d)  | (e)                  |
|-----|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|------|----------------------|
|     | Identity of issue,<br>borrower, lessor,<br>or similar party | Description of<br>investment, including<br>maturity date, rate of<br>interest, collateral,<br>par or maturity value | Cost | Current<br>value     |
|     | <b>Mutual funds:</b>                                        |                                                                                                                     |      |                      |
|     | JP Morgan                                                   | Large Cap Growth Fund                                                                                               | **   | \$ 2,349,627         |
|     | Metropolitan                                                | West T1 Rtn Bd Fd                                                                                                   | **   | 364,585              |
|     | MFS                                                         | Mid Cap Value Fund                                                                                                  | **   | 89,886               |
|     | MFS                                                         | International Diversification Fund                                                                                  | **   | 141,132              |
|     | BlackRock                                                   | Mid Cap Growth Equity Fd                                                                                            | **   | 231,626              |
|     | Vanguard                                                    | 500 Index Fund                                                                                                      | **   | 997,986              |
|     | Vanguard                                                    | Dvlpd Mrkts Indx Fd                                                                                                 | **   | 699,604              |
|     | Vanguard                                                    | Emrg Mrkts Stck Indx Fd                                                                                             | **   | 112,481              |
|     | Vanguard                                                    | Equity-Income Fund                                                                                                  | **   | 474,656              |
|     | Vanguard                                                    | Mid Cap Index Fund                                                                                                  | **   | 226,738              |
|     | Vanguard                                                    | Real Estate Index Fund                                                                                              | **   | 121,748              |
|     | Vanguard                                                    | Small Cap Index                                                                                                     | **   | 234,525              |
|     | Vanguard                                                    | Target Retirement 2015 Fd                                                                                           | **   | 54,336               |
|     | Vanguard                                                    | Target Retirement 2020 Fd                                                                                           | **   | 99,906               |
|     | Vanguard                                                    | Target Retirement 2025 Fd                                                                                           | **   | 315,078              |
|     | Vanguard                                                    | Target Retirement 2030 Fd                                                                                           | **   | 304,461              |
|     | Vanguard                                                    | Target Retirement 2035 Fd                                                                                           | **   | 487,665              |
|     | Vanguard                                                    | Target Retirement 2040 Fd                                                                                           | **   | 816,890              |
|     | Vanguard                                                    | Target Retirement 2045 Fd                                                                                           | **   | 478,320              |
|     | Vanguard                                                    | Target Retirement 2050 Fd                                                                                           | **   | 196,008              |
|     | Vanguard                                                    | Target Retirement 2055 Fd                                                                                           | **   | 189,828              |
|     | Vanguard                                                    | Target Retirement 2060 Fd                                                                                           | **   | 352,165              |
|     | Vanguard                                                    | Target Retirement incm Fd                                                                                           | **   | 23,063               |
|     | Vanguard                                                    | Total Bond Mrkt Index (U)                                                                                           | **   | 1                    |
|     | Vanguard                                                    | Total Bond Mrkt Index                                                                                               | **   | 430,802              |
|     | Allspring                                                   | Small Co Growth Fd                                                                                                  | **   | 434,695              |
|     | American Century                                            | Small Cap Value Fund                                                                                                | **   | <u>154,335</u>       |
|     |                                                             | Total mutual funds                                                                                                  |      | 10,382,147           |
| *   | Investment contract -<br>Great-West                         | SAGIC Core Bond II                                                                                                  | **   | 2,462,611            |
| *   | Notes receivable from participants                          | Interest rates ranging from 4.25%<br>to 6.50% with various maturity<br>dates through July 2026                      | -    | <u>99,596</u>        |
|     |                                                             | Total                                                                                                               |      | <u>\$ 12,944,354</u> |

\* Represents a party-in-interest.

\*\* Not required for participant directed plans.

The above data is based upon information which has been certified as complete and accurate by Great-West and Reliance Trust.

|                                                                                              |                                                             |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A Name of Plan</b><br><b>Nixon Power Services 401(k) Plan</b>                             | <b>B Three-digit plan Number</b><br><b>001</b>              |
| <b>C Plan sponsor's name as shown on line 2a of Form 5500</b><br><b>Nixon Power Services</b> | <b>D Employer Identification Number</b><br><b>421608629</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                                                                                 | 2,462,611 | 2,462,611         |
| *   | Wells Fargo                                               | Allspring Small Company Growth Fd                                                                           | 448,637   | 434,695           |
| *   | American Century                                          | American Century Small Cap Value Fd                                                                         | 156,089   | 154,335           |
| *   | Artisan                                                   | Artisan International Value Fund                                                                            | 0         | 0                 |
| *   | BlackRock                                                 | BlackRock Mid-Cap Growth Equity Fd                                                                          | 201,073   | 231,626           |
| *   | JP Morgan                                                 | JP Morgan Large Cap Growth Fund                                                                             | 1,567,088 | 2,349,584         |
| *   | MassMutual Premier                                        | Holding Account - MassMutual US Gov                                                                         | 0         | 45                |
| *   | Metropolitan West Asset Management                        | Metropolitan West Total Rtrn Bnd Fd                                                                         | 370,741   | 364,585           |
| *   | MFS Investment Management                                 | MFS Intl Diversification Fd                                                                                 | 122,217   | 141,132           |
| *   | MFS Investment Management                                 | MFS Mid Cap Value Fund                                                                                      | 75,532    | 89,886            |
| *   | Vanguard                                                  | Vanguard 500 Index Fund                                                                                     | 627,586   | 997,986           |
| *   | Vanguard                                                  | Vanguard Developed Markets Index Fd                                                                         | 556,556   | 699,604           |
| *   | Vanguard                                                  | Vanguard Emerg Mkts Stock Indx Fd                                                                           | 100,341   | 112,481           |
| *   | Vanguard                                                  | Vanguard Equity-Income Fund                                                                                 | 375,355   | 474,656           |
| *   | Vanguard                                                  | Vanguard Mid Cap Index Fund                                                                                 | 153,887   | 226,738           |
| *   | Vanguard                                                  | Vanguard Real Estate Index Fund                                                                             | 90,641    | 121,748           |
| *   | Vanguard                                                  | Vanguard Small Cap Index Fund                                                                               | 171,933   | 234,525           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2015 Fd                                                                              | 57,956    | 54,336            |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2020 Fd                                                                              | 101,645   | 99,906            |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2025 Fd                                                                              | 296,952   | 315,078           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2030 Fd                                                                              | 287,084   | 304,461           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2035 Fd                                                                              | 463,685   | 487,665           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2040 Fd                                                                              | 737,821   | 816,890           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2045 Fd                                                                              | 415,964   | 478,320           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2050 Fd                                                                              | 170,207   | 196,008           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2055 Fd                                                                              | 163,859   | 189,828           |
| *   | Vanguard                                                  | Vanguard Target Retmnt 2060 Fd                                                                              | 297,033   | 352,165           |
| *   | Vanguard                                                  | Vanguard Target Retmnt Incm Fd                                                                              | 23,469    | 23,063            |
| *   | Vanguard                                                  | Vanguard Total Bond Mrkt Index Fund                                                                         | 423,576   | 430,803           |
| *   | Victory                                                   | Victory Integrity Small-Cap Val Fd                                                                          | 0         | 0                 |
|     | Participant Loans                                         | 4.250000 - 6.500000                                                                                         | 0         | 99,596            |