Cumulative e-File History 2020	
Federal	
Locator:	52086K
Account:	F173
Taxpayer Name:	SO NEVADA CULINARY AND BARTENDERS PENSION PLN
Return Type:	5500
Submitted Date:	10/14/2021 19:39:37
Acknowledgement Date:	10/14/2021 19:56:35
Status:	Accepted
Submission ID:	886016617211014195006

Authorized Multiemployer Plan e-Signature Affidavit

Southern Nevada Culinary and Bartenders Pension Plan; E.I.N. 88-6016617; Plan No. 001

Form 5500 for the year beginning January 1, 2020 and ending December 31, 2020

By signing below, we represent that we are authorized to act on behalf of the Board of Trustees of the above referenced plan, which is the plan administrator, and we authorize Miller Kaplan Arase LLP ("MKA") to electronically submit Form 5500 on its behalf under the "additional e-signature option." MKA will maintain a copy of this authorization for its records.

We have manually signed the Form 5500 and understand that MKA will attach to the electronic filing, in addition to any other required schedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 bearing our manual signatures. We further understand that the PDF image of our manual signatures will be included with the Form 5500 posted by the U.S. Department of Labor (DOL) on the Internet for public disclosure.

We understand that MKA will communicate to us, and to the Board of Trustees of the plan, any inquiries and information received from EFAST2, DOL, IRS or PBGC regarding this Form 5500 annual return/report.

Virginia Valentine - Virginia Valentine - 10 / 12 / 2021
UNION TRUSTEE (Print Name – Signature - Date)

Terry Greenwald - [signature] - 10 / 12 / 2021
EMPLOYER TRUSTEE (Print Name – Signature - Date)

Form **5558** (Rev. September 2018)

Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.
▶ Go to *www.irs.gov/Form5558* for the latest information.

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)
BOARD OF TRUSTEES, (OF THE BELOW PLAN)
Number, street, and room or suite no. (If a P.O. box, see instructions)
9121 W RUSSELL RD STE 219
City or town, state, and ZIP code
LAS VEGAS, NV 89148

B **Filer's identifying number (see instructions)**
Employer identification number (EIN) (9 digits XX-XXXXXXX)
88-6016617
Social security number (SSN) (9 digits XXX-XX-XXXX)

C Plan name	Plan number	Plan year ending - MM	DD	YYYY
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN	001	12	31	2020

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.

2 I request an extension of time until 10/15/2021 to file Form 5500 series. See instructions.
Note: A signature IS NOT required if you are requesting an extension to file Form 5500 series.

3 I request an extension of time until 10/15/2021 to file Form 8955-SSA. See instructions.
Note: A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.

Part III Extension of Time To File Form 5330 *(see instructions)*

4 I request an extension of time until ____________ to file Form 5330.
You may be approved for up to a 6-month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ▶ **a**

b Enter the payment amount attached . . . . . ▶ **b**

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . . ▶ **c**

5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ **Date** ▶

Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2020** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning and ending

A This return/report is for: [X] 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 ▶ [X]

D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program

[ ] special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/1971

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BD. OF TRUSTEES, (OF THE ABOVE PLAN)
SOUTHERN NEVADA CULINARY AND
BARTENDERS PENSION PLAN
9121 W RUSSELL RD STE 219
LAS VEGAS NV 89148

2b Employer Identification Number (EIN) 88-6016617

2c Plan Sponsor's telephone number 702-369-0000

2d Business code (see instructions) 721120

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

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

SIGN HERE	Virginia Valentine Signature of plan administrator	10/12/2021 Date	Virginia Valentine Enter name of individual signing as plan administrator
SIGN HERE	[signature] Signature of employer/plan sponsor	10/12/2021 Date	Terry Greenbach Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. **Form 5500 (2020)** **v. 200204**

0A6704 1.000

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

3b Administrator's EIN
88-6016617

3c Administrator's telephone number
702-369-0000

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

4b EIN

a Sponsor's name

4d PN

c Plan Name

Line	Description	Box	Value
5	Total number of participants at the beginning of the plan year	5	107812
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	6a(1)	55852
a(2)	Total number of active participants at the end of the plan year	6a(2)	46573
b	Retired or separated participants receiving benefits	6b	26433
c	Other retired or separated participants entitled to future benefits	6c	27303
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	6d	100309
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	1314
f	Total. Add lines **6d** and **6e**.	6f	101623
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	0.
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	0.
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	104

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
1B

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

9a Plan funding arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code ______________________

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2020** **This Form is Open to Public Inspection**

For calendar plan year 2020 or fiscal plan year beginning and ending

A Name of plan	**B** Three-digit plan number (PN) ▶
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN	001
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BD. OF TRUSTEES,(OF THE ABOVE PLAN)	88-6016617

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

THE UNION LABOR LIFE INSURANCE CO.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
13-1423090	69744			01/01/2020	12/31/2020

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)** Organ-ization 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)** Organ-ization 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)** Organ-ization 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)** Organ-ization 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)** Organ-ization 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)** Organ-ization 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)** Organ-ization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	43705000

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

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

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

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

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

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) ▶						

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	**Service Provider Information** This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	OMB No. 1210-0110 **2020** **This Form is Open to Public Inspection.**

For calendar plan year 2020 or fiscal plan year beginning and ending

A Name of plan SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN	**B** Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 BD. OF TRUSTEES,(OF THE ABOVE PLAN)	**D** Employer Identification Number (EIN) 88-6016617

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

PIMCO 33-0629048

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

LANDMARK EQUITY ADVISORS, LLC 06-1519082

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

ENTRUST GLOBAL PARTNERS, LLC 13-4021839

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

PNC BANK, NATIONAL ASSOCIATION 22-1146430

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

AFL-CIO HOUSING INVESTMENT TRUST 52-6220193

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

HAMILTON LANE ADVISORS, LLC 23-2962336

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

ABS INVESTMENT MANAGEMENT LLC 13-4205457

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

LAZARD ASSET MANAGEMENT, LLC 05-0530199

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

MESIROW FINANCIAL PARTNERSHIP FD VI 27-3525125

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

GAM USA, INC. 22-1146430

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

NEW TOWER TRUST COMPANY 30-0872552

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

MCMORGAN & COMPANY LLC 52-2334338

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

ENTRUST SO NV CUL. & BART. PARTNERS 81-2026132

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

OAKTREE CAPITAL MANAGEMENT L.P. 26-0189082

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

INVESCO ADVISERS, INC. 58-1707262

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

GCM GROSVENOR MULTI-ASSET CLASS MAS 37-1876536

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

SIGULER GUFF ADVISERS, LLC 13-3855629

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

BLACKROCK, INC. 32-0174431

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

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

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

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

ZENITH AMERICAN SOLUTIONS 95-1702986

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	2,927,962.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

LOOMIS SAYLES & COMPANY 84-6391546

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	823,934.	Yes ☒ No ☐	Yes ☐ No ☒	0.	Yes ☒ No ☐

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

HARDMAN JOHNSTON GLOBAL ADVISORS 26-6493485

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	779,498.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

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

J.P. MORGAN INVESTMENT MGMT, INC. 13-3200244

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50 28 51	NONE	651,660.	Yes [ ] No [X]	Yes [ ] No [ ]	0.	Yes [ ] No [ ]

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

TIMESSQUARE CAPITAL MANAGEMENT LLC 20-1665304

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 52 51	NONE	622,788.	Yes [X] No [ ]	Yes [X] No [ ]	0.	Yes [X] No [ ]

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

INVESCO TRUST COMPANY 46-3793325

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28	NONE	506,225.	Yes [X] No [ ]	Yes [X] No [ ]	0.	Yes [X] No [ ]

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

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

INTECH INVESTMENT MANAGEMENT LLC 01-0614895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	505,400.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

SEYFARTH & SHAW ATTORNEYS, LLP 36-2152202

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	419,859.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

VOYA INVESTMENT TRUST COMPANY 06-1440627

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	381,715.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☒

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

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

HORIZON ACTUARIAL SERVICES, LLC 26-1370698

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	349,802.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

ORG PORTFOLIO MANAGEMENT, LLC 20-2915624

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	318,000.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

THE UNION LABOR LIFE INSURANCE COMP 13-1423090

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	316,088.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☒

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

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

MARCO CONSULTING GROUP 36-3555078

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 27	NONE	275,000.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

WEDGE CAPITAL MANAGEMENT LLP 56-1557450

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 52 51 68	NONE	274,869.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☒

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

COLUMBIA MGMT INVESTMENT ADVISORS 41-1533211

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 68 51	NONE	214,061.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☐ No ☒

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

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

DIMENSIONAL FUND ADVISORS LP 30-0447847

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	194,555.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

LSV ASSET MANAGEMENT 23-2772200

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	179,466.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

WELLS FARGO BANK 30-0447847

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19	NONE	132,468.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☒ No ☐

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

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

MILLER KAPLAN ARASE LLP 95-2036255

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	117,236.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

WESTERN ASSET MANAGEMENT COMPANY 95-2705767

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	108,670.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

MCCRACKEN, STEMERMAN & HOLSBERRY 94-1709555

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	80,085.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

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

PARAMETRIC CLIFTON 20-0292745

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 52 51	NONE	71,186.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

UNITE HERE HEALTH 23-7385560

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	54,885.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

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

KEVIN CHRISTENSEN, ESQ 80-0024644

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	30,677.	Yes ☐ No ☒	Yes ☐ No ☐	0.	Yes ☐ No ☐

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning and ending

A Name of plan
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
BD. OF TRUSTEES,(OF THE ABOVE PLAN)

D Employer Identification Number (EIN)
88-6016617

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

a Name of MTIA, CCT, PSA, or 103-12 IE: JP MORGAN STRATEGIC PROPERTY FUND
b Name of sponsor of entity listed in (a): JP MORGAN ASSET MANAGEMENT
c EIN-PN 13-6038770 - 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 65771488

a Name of MTIA, CCT, PSA, or 103-12 IE: LOOMIS SAYLES MULTISECTOR FULL DIS.
b Name of sponsor of entity listed in (a): LOOMIS SAYLES & TRUST COMPANY, LLC
c EIN-PN 84-6391546 - 007 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 89339127

a Name of MTIA, CCT, PSA, or 103-12 IE: MULTI-EMPLOYER PROPERTY TRUST
b Name of sponsor of entity listed in (a): NEW TOWER TRUST COMPANY
c EIN-PN 52-6218800 - 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 99110450

a Name of MTIA, CCT, PSA, or 103-12 IE: AFL-CIO BUILDING INVESTMENT TRUST
b Name of sponsor of entity listed in (a): PNC BANK, NATIONAL ASSOCIATION
c EIN-PN 52-6328901 - 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 100563125

a Name of MTIA, CCT, PSA, or 103-12 IE: DFA GROUP TRUST - SMALL CAP SUB TRU
b Name of sponsor of entity listed in (a): DFA LP
c EIN-PN 23-6819730 - 005 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 74973000

a Name of MTIA, CCT, PSA, or 103-12 IE: VOYA SENIOR LOAN TRUST
b Name of sponsor of entity listed in (a): VOYA INVESTMENT TRUST CO.
c EIN-PN 06-1440627 - 045 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 89123927

a Name of MTIA, CCT, PSA, or 103-12 IE: WESTERN ASSET US CORE PLUS, LLC
b Name of sponsor of entity listed in (a): WESTERN ASSET MANAGEMENT CO.
c EIN-PN 20-1575788 - 001 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 32583000

a Name of MTIA, CCT, PSA, or 103-12 IE: MCMORGAN INFRASTRUCTURE FUND I, LP

b Name of sponsor of entity listed in (a): MCMORGAN INFRASTRUCTURE GP LLC

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
30-0808269-001	E	80659000

a Name of MTIA, CCT, PSA, or 103-12 IE: JOHNSTON INTERNATIONAL EQUITY GROUP

b Name of sponsor of entity listed in (a): HARDMAN JOHNSTON GLOBAL ADVISORS

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
26-6493485-001	E	167844000

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

b Name of sponsor of entity listed in (a): THE UNION LABOR LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
13-1423090-203	P	43705000

a Name of MTIA, CCT, PSA, or 103-12 IE: WF/BLACKROCK S&P MIDCAP INDEX CIT

b Name of sponsor of entity listed in (a): WELLS FARGO BANK, N.A.

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
56-6288528-001	C	90241731

a Name of MTIA, CCT, PSA, or 103-12 IE: INVESCO MACRO ALLOCATION STRATEGY

b Name of sponsor of entity listed in (a): INVESCO TRUST COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
81-2234495-001	C	84972696

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)

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

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2020** **This Form is Open to Public Inspection**

For calendar plan year 2020 or fiscal plan year beginning and ending

A Name of plan
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TRUSTEES,(OF THE ABOVE PLAN)

D Employer Identification Number (EIN)
88-6016617

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	7616000	9768000
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	10094000	5178000
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	21598000	11063000
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	26612000	32376000
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	519214000	554337000
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)	35233000	36798000
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	593215000	619123000
(10) Value of interest in pooled separate accounts	1c(10)	42891000	43705000
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)	297528000	356059000
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	272612000	276559000
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	650980000	706965000

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	2477593000	2651931000
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	1756000	2056000
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	1756000	2056000
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	2475837000	2649875000

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a **Contributions:**			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	65683000	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		65683000
b **Earnings on investments:**			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	228000	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		228000
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	8536000	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	8447000	
(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		16983000
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	437413000	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	431840000	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		5573000
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	179965000	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		179965000

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		34166000
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		1106000
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		64208000
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		5620000
c Other income	2c		8000
d Total income. Add all **income** amounts in column (b) and enter total	2d		373540000
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	184747000	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		184747000
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)	1193000	
(2) Contract administrator fees	2i(2)	2918000	
(3) Investment advisory and management fees	2i(3)	6305000	
(4) Other	2i(4)	4339000	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		14755000
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		199502000
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		174038000
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):
(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.
(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] 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: MILLER KAPLAN ARASE LLP **(2)** EIN: 95-2036255

d The opinion of an independent qualified public accountant is **not attached** because:
(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

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

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

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

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

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

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

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

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

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4323200 .

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning and ending

A Name of plan
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TRUSTEES,(OF THE ABOVE PLAN)

D Employer Identification Number (EIN)
88-6016617

Part I Distributions

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 88-6016617 ____________

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year. **3** 116

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

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

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

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

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

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) **6a**

b Enter the amount contributed by the employer to the plan for this plan year **6b**

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c** 0

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V **Additional Information for Multiemployer Defined Benefit Pension Plans**

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

a Name of contributing employer WYNN LAS VEGAS
b EIN 88-0494875 **c** Dollar amount contributed by employer 7587016
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 07 Day 31 Year 2021
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) 1.31
(2) Base unit measure: [X] Hourly [ ] Weekly [ ] Unit of production [ ] Other (specify):

a Name of contributing employer BELLAGIO
b EIN 94-3373852 **c** Dollar amount contributed by employer 5202862
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 05 Day 31 Year 2023
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) 1.41
(2) Base unit measure: [X] Hourly [ ] Weekly [ ] Unit of production [ ] Other (specify):

a Name of contributing employer CAESAR'S PALACE
b EIN 88-0097966 **c** Dollar amount contributed by employer 4489187
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 05 Day 31 Year 2023
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) 1.41
(2) Base unit measure: [X] Hourly [ ] Weekly [ ] Unit of production [ ] Other (specify):

a Name of contributing employer ARIA RESORT & CASINO
b EIN 20-5396350 **c** Dollar amount contributed by employer 4448765
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 05 Day 31 Year 2023
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) 1.41
(2) Base unit measure: [X] Hourly [ ] Weekly [ ] Unit of production [ ] Other (specify):

a Name of contributing employer MGM GRAND HOTEL, INC
b EIN 94-3373856 **c** Dollar amount contributed by employer 3965219
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 05 Day 31 Year 2023
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) 1.41
(2) Base unit measure: [X] Hourly [ ] Weekly [ ] Unit of production [ ] Other (specify):

a Name of contributing employer MANDALAY BAY
b EIN 88-0384693 **c** Dollar amount contributed by employer 3616556
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* [X] *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month 05 Day 31 Year 2023
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) 1.41
(2) Base unit measure: [X] 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: [X] 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**	1.03
b The corresponding number for the second preceding plan year	**15b**	1.06

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: 49.4 % Investment-Grade Debt: 8.6 % High-Yield Debt: 7.4 % Real Estate: 13.2 % Other: 21.4 %

b Provide the average duration of the combined investment-grade and high-yield debt:

[ ] 0-3 years [ ] 3-6 years [X] 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)?

[X] 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

SCHEDULE MB (Form 5500)	Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500 or 5500-SF.**	**2020** **This Form is Open to Public Inspection**

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

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

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

A Name of plan Southern Nevada Culinary and Bartenders Pension Plan	**B** Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF BOARD OF TRUSTEES	**D** Employer Identification Number (EIN) 88-6016617

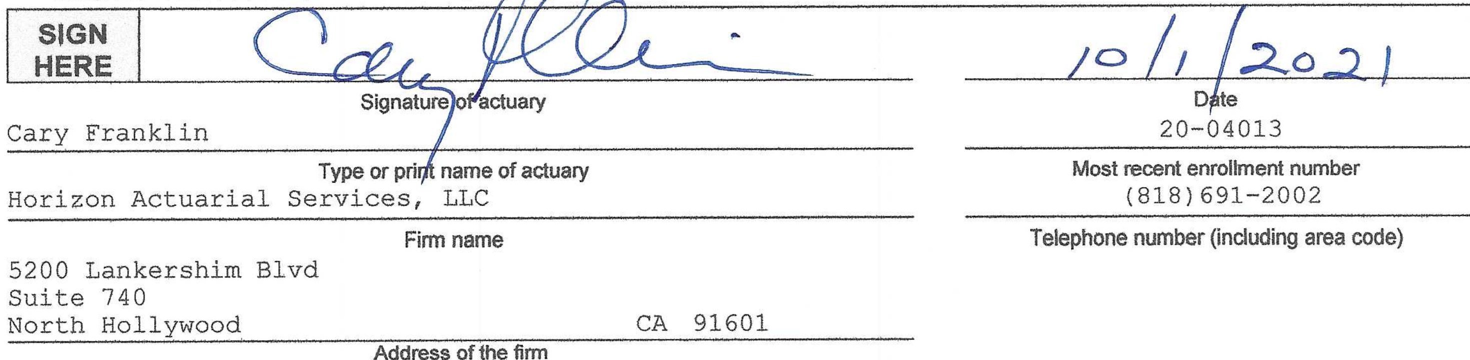
E Type of plan: (1) ☒ Multiemployer Defined Benefit (2) ☐ Money Purchase (see instructions)

1a Enter the valuation date: Month 1 Day 1 Year 2020

b Assets		
(1) Current value of assets	1b(1)	2,475,837,000
(2) Actuarial value of assets for funding standard account	1b(2)	2,391,481,214
c (1) Accrued liability for plan using immediate gain methods	1c(1)	2,829,171,130
(2) Information for plans using spread gain methods:		
(a) Unfunded liability for methods with bases	1c(2)(a)	
(b) Accrued liability under entry age normal method	1c(2)(b)	
(c) Normal cost under entry age normal method	1c(2)(c)	
(3) Accrued liability under unit credit cost method	1c(3)	2,829,171,130
d Information on current liabilities of the plan:		
(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1)	
(2) "RPA '94" information:		
(a) Current liability	1d(2)(a)	5,027,212,118
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	164,400,796
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	208,383,878
(3) Expected plan disbursements for the plan year	1d(3)	204,740,359

Statement by Enrolled Actuary

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



SIGN HERE [signature] 10/1/2021

Signature of actuary — Date

Cary Franklin — 20-04013

Type or print name of actuary — Most recent enrollment number

Horizon Actuarial Services, LLC — (818)691-2002

Firm name — Telephone number (including area code)

5200 Lankershim Blvd
Suite 740
North Hollywood CA 91601

Address of the firm

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

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

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions) **2a** 2,475,837,000

b "RPA '94" current liability/participant count breakdown:

	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	28,318	1,481,938,702
(2) For terminated vested participants	23,421	1,009,028,828
(3) For active participants:		
(a) Non-vested benefits		45,277,058
(b) Vested benefits		2,490,967,530
(c) Total active	52,476	2,536,244,588
(4) Total	104,215	5,027,212,118

c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage ..... **2c** 49.25 %

3 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	c) Amount paid by employees
	65,683,000				
			Totals ► 3(b)	65,683,000	3(c) 0

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)) ..... **4a** 84.5 %

b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5 ..... **4b** N

c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? ..... ☐ Yes ☐ No

d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? ..... ☐ Yes ☐ No

e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date **4e**

f If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge.
If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here ..... ☐ **4f**

5 Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

a ☐ Attained age normal **b** ☐ Entry age normal **c** ☒ Accrued benefit (unit credit) **d** ☐ Aggregate

e ☐ Frozen initial liability **f** ☐ Individual level premium **g** ☐ Individual aggregate **h** ☐ Shortfall

i ☐ Other (specify):

j If box h is checked, enter period of use of shortfall method **5j**

k Has a change been made in funding method for this plan year? ..... ☒ Yes ☐ No

l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? ..... ☒ Yes ☐ No

m If line k is "Yes," and line l is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method **5m**

3(a) Contributions made throughout the year. No withdrawal liability payments.

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability ..... **6a** 2.95 %

		Pre-retirement		Post-retirement	
b Rates specified in insurance or annuity contracts		☐ Yes ☒ No ☐ N/A		☐ Yes ☒ No ☐ N/A	
c Mortality table code for valuation purposes:					
(1) Males	6c(1)	13+2		13+2	
(2) Females	6c(2)	13F+2		13F+2	
d Valuation liability interest rate	6d	7.00 %		7.00 %	
e Expense loading	6e	10.2 %	☐ N/A	%	☒ N/A
f Salary scale	6f	%	☒ N/A		

g Estimated investment return on actuarial value of assets for year ending on the valuation date ..... **6g** 6.7 %

h Estimated investment return on current value of assets for year ending on the valuation date ..... **6h** 16.9 %

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	35,124,492	3,604,187
4	66,742,322	6,848,550

8 Miscellaneous information:

a If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM-DD-YYYY) of the ruling letter granting the approval **8a**

b(1) Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule. ..... ☒ Yes ☐ No

b(2) Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule. ..... ☒ Yes ☐ No

c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code? ..... ☐ Yes ☒ No

d If line c is "Yes," provide the following additional information:

(1) Was an extension granted automatic approval under section 431(d)(1) of the Code? ..... ☐ Yes ☐ No

(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended ..... **8d(2)**

(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code? ..... ☐ Yes ☐ No

(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2)) ..... **8d(4)**

(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension ..... **8d(5)**

(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007? ..... ☐ Yes ☐ No

e If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(s) **8e**

9 Funding standard account statement for this plan year:

Charges to funding standard account:

		Outstanding balance	
a Prior year funding deficiency, if any	9a		0
b Employer's normal cost for plan year as of valuation date	9b		80,904,736
c Amortization charges as of valuation date:			
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	1,122,408,206	134,450,177
(2) Funding waivers	9c(2)	0	0
(3) Certain bases for which the amortization period has been extended	9c(3)	0	0
d Interest as applicable on lines 9a, 9b, and 9c	9d		15,074,844
e Total charges. Add lines 9a through 9d	9e		230,429,757

Credits to funding standard account:

		Outstanding balance		
f Prior year credit balance, if any			9f	426,137,791
g Employer contributions. Total from column (b) of line 3			9g	65,683,000
h Amortization credits as of valuation date	9h	285,580,499		48,340,682
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h			9i	35,129,247
j Full funding limitation (FFL) and credits:				
(1) ERISA FFL (accrued liability FFL)	9j(1)	1,010,863,690		
(2) "RPA '94" override (90% current liability FFL)	9j(2)	2,283,255,119		
(3) FFL credit			9j(3)	0
k (1) Waived funding deficiency			9k(1)	0
(2) Other credits			9k(2)	0
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)			9l	575,290,720
m Credit balance: If line 9l is greater than line 9e, enter the difference			9m	344,860,963
n Funding deficiency: If line 9e is greater than line 9l, enter the difference			9n	

9 o Current year's accumulated reconciliation account:		
(1) Due to waived funding deficiency accumulated prior to the 2020 plan year	9o(1)	0
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
(a) Reconciliation outstanding balance as of valuation date	9o(2)(a)	0
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))	9o(2)(b)	0
(3) Total as of valuation date	9o(3)	0
10 Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)	10	

11 Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions. ☒ Yes ☐ No

Exhibit A.1 - Distribution of Active Participants

Measurement Date: January 1, 2020 [Form 5500 Sch. MB, Line 8b(2)]

Years of Credited Service

Age	Under 1	1 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 +	Total
Under 25	-	2,122	11	-	-	-	-	-	-	-	2,133
25 - 29	-	5,050	160	-	-	-	-	-	-	-	5,210
30 - 34	-	4,382	1,020	256	-	-	-	-	-	-	5,658
35 - 39	-	3,420	1,326	1,050	159	-	-	-	-	-	5,955
40 - 44	-	2,645	1,220	1,353	884	105	1	-	-	-	6,208
45 - 49	-	2,326	1,195	1,641	1,307	528	145	-	-	-	7,142
50 - 54	-	1,894	1,217	1,728	1,734	888	560	90	1	-	8,112
55 - 59	-	1,411	1,017	1,533	1,755	984	676	262	123	1	7,762
60 - 64	-	735	499	718	737	424	272	148	145	18	3,696
65 - 69	-	216	83	90	53	14	9	3	7	3	478
70 +	-	68	23	16	6	4	2	1	2	-	122
Total	-	24,269	7,771	8,385	6,635	2,947	1,665	504	278	22	52,476

Males	24,963
Females	27,513
Total	52,476

Average Age	44.64
Average Credited Service	10.37
Number Fully Vested	26,850
Number Nonvested	25,626

Notes

- An active participant is a participant who has at least one year of Credited Service, and who worked at least 300 hours in the Plan Year before the valuation date.

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Schedule MB, Line 6
Statement of Actuarial Assumptions/Methods

Plan Name	**Southern Nevada Culinary and Bartenders Pension Plan**
Plan Sponsor	Board of Trustees
EIN / PN	88-6016617 / 001

While it is important that the overall assumptions be reasonable, we select each valuation assumption as reasonable in light of this plan's provisions and characteristics. We have chosen the assumptions after reviewing recent plan experience and anticipated plan experience, and applying professional judgment, as described below.

Interest Rates

7.00% per annum, compounded annually, net of investment expense for determining costs and liabilities.

This interest rate assumptions, used for purposes of the ERISA funding valuation and ASC 960 accounting disclosure, is a reasonable estimate of the net investment return for the Plan assets over the long term. This assumption was developed based on our professional judgment, the investment policy and asset allocation for the Plan (as set by the plan sponsor) and considers the results of the 2020 edition of the Survey of Capital Market Assumptions by Horizon Actuarial Services, LLC.

The highest rate within the IRS allowable range for determining Current Liability, which 2.95% per annum as of January 1, 2020.

Retirement Age

Active participants: Retirement rates for those who have met the applicable eligibility requirements are show in the table below (weighted average retirement age: 62.9):

Age	Percent Retiring
62	65.0%
63	40.0%
64	40.0%
65	45.0%
66-69	35.0%
70+	100.0%

Inactive vested participants: 100% are assumed to retire at age 62 (or current age, if older).

Operating Expenses	Expenses are assumed to be $7,800,000, payable monthly, added to the Plan's normal cost. Investment counseling and investment management fees are not included in assumed operating expenses. (Expenses were also assumed to be $7,800,000 for the January 1, 2019 valuation.) This assumption is selected based on a review of recent years' operating expenses and anticipated future changes in expenses, including inflation.
Hours Worked	For the purpose of projecting future benefit accruals, it is assumed that each active participant will work the same number of hours per year as worked during the Plan Year preceding the valuation date.
Contribution Income	101,400,000 hours are assumed to be worked during 2020 at a contribution rate of $1.305 per hour through May 2020 and $1.405 per hour thereafter. (Prior year valuation assumed 99,000,000 hours at a contribution rate of $1.205 per hour through May 2019 and $1.305 per hour thereafter).
Active Participant	For valuation purposes, an active participant is a participant who has at least one year of Credited Service, and who worked at least 300 hours in the Plan Year ended December 31, 2019, and had not retired as of January 1, 2020.
Non-Disabled Mortality	RP-2014 Blue Collar Healthy Mortality with two-year set forward (separate male and female tables) and no future improvement in mortality rates beyond any included in published table. Prior assumption was RP-2000 Blue Collar mortality (separate male and female tables). The non-disabled mortality assumption was chosen based on a review of standard mortality tables, and projection scales, historical and current demographic data, and reflecting anticipated future experience and professional judgment. For determining the RPA '94 current liability, the mortality tables prescribed by the PPA were used.

Disabled Mortality

PBGC Mortality Tables (separate male and female tables) for disabled lives receiving Social Security benefits with no future improvement in mortality rates beyond any included in the published table.

The disabled mortality assumption was chosen based on a review of standard mortality tables and projection scales, historical and current demographic data, and reflecting anticipated future experience and professional judgment.

For determining the RPA '94 current liability, the mortality tables prescribed by the PPA were used.

Disability

Illustrations of the annual rates of disablement are shown in the table below for selected ages (the same rates are used for males and females):

Representative Disability Rates

Age	Males and Females
20	0.015%
25	0.023%
30	0.028%
35	0.038%
40	0.055%
45	0.090%
50	0.153%
55	0.253%
60	0.408%

Withdrawal

Illustrations of the annual rates of withdrawal (for reasons other than mortality or disablement) are shown in the table below for selected ages:

Representative Withdrawal Rates

Age	Males and Females
20	20.00%
25	16.00%
30	13.00%
35	10.00%
40	8.00%
45	8.00%
50	5.00%
55	5.00%
60	5.00%

Reemployment

It is assumed that participants will not be reemployed following a break in service.

Form of Payment	All participants who retire from active service are assumed to elect to receive one-half of their accrued benefit as a single life annuity and one-half in a lump sum at retirement. The lump sum is limited to $50,000. 75% of inactive vested participants are assumed to receive one-half of their benefit as a lump sum (limited to $50,000) at age 62 with the remaining benefit assumed payable as a single life annuity, and 25% are assumed to receive their benefit as a single life annuity.
Marriage	50% of non-retired participants are assumed to be married.
Spouse Ages	Spouse of a male participant is 4 years younger than the participant; spouse of a female participant is 4 years older than the participant.
Inactive Vested Participants	It is assumed that inactive vested participants who have not applied for pension benefits by age 70 will not do so.
Lump Sum Conversion	PPA Unisex Combined Mortality Table for 2019 and 6.25% interest. (Prior valuation used 2017 PPA Unisex Combined Mortality Table and 6.25% interest.)
Cost Method	Costs and liabilities for all Plan benefits were determined based on the Unit Credit Cost Method. The Unit Credit Cost Method is used to determine the normal cost and the actuarial accrued liability. The actuarial accrued liability is the present value of the accrued benefits as of the beginning of the year for active participants and is the present value of all benefits for other participants. The normal cost is the present value of the difference between the accrued benefits as of the beginning and end of the year. The normal cost and actuarial accrued liability for the plan are the sums of the individually computed normal costs and actuarial accrued liabilities for all Plan participants; however, the sum of the individual normal costs is then adjusted by the ratio of the assumed contributory hours for the coming year to the total actual contributory hours for the prior year.

Asset Valuation Method	The actuarial value of assets is determined by adjusting the market value of assets to reflect the investment gains and losses (the difference between the actual investment return and the assumed investment return) during each of the last five years at the rate of 20% per year. Expected investment return is calculated using the net market value of assets as of the beginning of the Plan Year and the benefit payments, employer contributions and operating expenses, weighted based on the timing of the transactions during the year. The actuarial value is subject to a restriction that it be not less than 80% nor more than 120% of the market value.
Participant Data	Actuarial valuation was prepared based on data files for active, retired, and inactive vested participants furnished by Zenith American Solutions.
Missing or Incomplete Participant Data	Assumptions were made to adjust for participants and beneficiaries with missing or incomplete data, based on those exhibited by participants with similar known characteristics.
Financial Information	Financial information was obtained from the audited financial statements filed with the 2019 Form 5500.
Nature of Actuarial Calculations	The valuation results presented in this report are estimates. The results are based on data that may be imperfect and on assumptions made about future events. Certain plan provisions may be approximated or deemed immaterial for the purposes of the valuation. Assumptions may be made about missing or incomplete participant census data or other factors. Reasonable efforts were made to ensure that significant items and factors are included in the valuation and treated appropriately. A range of results different from those presented in this report could also be considered reasonable. The actuarial assumptions selected for this valuation – including the valuation interest rate – generally reflect average expectations over the long term. If overall future demographic or investment experience is less favorable than assumed, the relative level of plan costs determined in this valuation will likely increase in future valuations. Investment returns and demographic factors may fluctuate significantly from year to year. The deterministic actuarial models used in this valuation do not take into consideration the possibility of such volatility.

Change in Method	There was a change in actuarial valuation software for the actuarial valuation as of January 1, 2020. This constitutes a method change under Revenue Procedure 2000-40. However, in accordance with RP 2000-40, since the change in valuation software resulted in a minimal change in benefit liabilities and the net changes to the funding standard account changed by less than 2%, the change in software is treated as an experience gain or loss, rather than as a method change, for purposes of the funding standard account.
Changes in Assumptions	Since the prior valuation, the following assumptions have been changed: • **Non-Disabled Participant Mortality –** RP-2014 Blue Collar Healthy Mortality Table with two-year set forward (separate male and female tables). Prior valuation assumed RP-2000 Combined Blue Collar mortality (separate male and female tables) • **Contribution Income –** It is assumed that 101,400,000 hours are worked each year at a contribution rate of $1.305 per hour through May 31, 2020 and $1.405 per hour thereafter. (Prior valuation assumed 99,000,000 hours at a rate of $1.205 per hour through May 31, 2019 and $1.305 per hours thereafter) • **Lump Sum Conversion –** The basis to determine lump sums was updated to 2020 PPA Unisex Combined Mortality Table and 5.75% interest. (Prior valuation used 2019 PPA Unisex Combined Mortality Table and 6.25% interest.)
Justification for Changes in Assumptions and Methods	Based on the results of the 2020 comprehensive experience study, the changes in the actuarial assumption described above were made to better reflect recent and anticipated Plan experience.

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Exhibit 4.2 - Funding Standard Account Amortization Bases

Charges [Schedule MB, Line 9c]

Type	Date Established	Initial Period	*Outstanding at 1/1/2020* Period	Balance	Annual Payment
Amendment	1/1/1991	30.00	1.00	$ 351,333	$ 351,333
Amendment	1/1/1993	30.00	3.00	4,020,653	1,431,846
Amendment	1/1/1994	30.00	4.00	3,330,338	918,889
Amendment	1/1/1997	30.00	7.00	4,270,964	740,647
Amendment	1/1/1998	30.00	8.00	22,466,076	3,516,210
Amendment	1/1/1999	30.00	9.00	47,262,629	6,779,603
Assumption	1/1/1999	30.00	9.00	20,363,020	2,920,979
Amendment	1/1/2000	30.00	10.00	6,817,364	907,140
Amendment	1/1/2003	30.00	13.00	5,797,151	648,257
Amendment	1/1/2005	30.00	15.00	19,564,418	2,007,541
Exper Loss	1/1/2006	15.00	1.00	6,845,653	6,845,653
Exper Loss	1/1/2007	15.00	2.00	7,485,604	3,869,367
ENIL (2008)	1/1/2009	29.00	18.00	253,288,442	23,532,769
ENIL (2008)	1/1/2010	28.00	18.00	38,577,947	3,584,237
ENIL (2008)	1/1/2011	27.00	18.00	40,615,838	3,773,575
ENIL (2008)	1/1/2012	26.00	18.00	32,698,121	3,037,948
Assumption	1/1/2012	15.00	7.00	1,916,045	332,270
Exper Loss	1/1/2012	15.00	7.00	42,870,225	7,434,306
ENIL (2008)	1/1/2013	25.00	18.00	33,086,787	3,074,060
ENIL (2008)	1/1/2014	24.00	18.00	83,796,867	7,785,481
Assumption	1/1/2014	15.00	9.00	40,873,821	5,863,157
Exper Loss	1/1/2015	15.00	10.00	13,114,935	1,745,114
Exper Loss	1/1/2016	15.00	11.00	42,449,614	5,290,607
Exper Loss	1/1/2017	15.00	12.00	32,162,266	3,784,386
Exper Loss	1/1/2018	15.00	13.00	27,561,082	3,081,969
Amendment	1/1/2018	15.00	13.00	110,432,848	12,348,957
Exper Loss	1/1/2019	15.00	14.00	61,593,856	6,582,192
Assumption	1/1/2019	15.00	14.00	16,927,495	1,808,947
Exper Loss	1/1/2020	15.00	15.00	35,124,492	3,604,187
Assumption	1/1/2020	15.00	15.00	66,742,322	6,848,550
Total Charges				$1,122,408,206	$ 134,450,177

Exhibit 4.2 - Funding Standard Account Amortization Bases (Cont.)

Credits [Schedule MB, Line 9h]

Type	Date Established	Initial Period	*Outstanding at 1/1/2020* Period	Balance	Annual Payment
Assumption	1/1/1994	30.00	4.00	$ 399,586	$ 110,250
Assumption	1/1/1997	30.00	7.00	267,459	46,380
Assumption	1/1/2001	30.00	11.00	1,089,510	135,789
Assumption	1/1/2002	30.00	12.00	1,529,882	180,015
Assumption	1/1/2003	30.00	13.00	1,703,520	190,493
Assumption	1/1/2004	30.00	14.00	1,887,136	201,667
Assumption	1/1/2006	30.00	16.00	1,753,268	173,455
Assumption	1/1/2007	30.00	17.00	30,079,284	2,879,323
Method	1/1/2008	15.00	3.00	13,440,390	4,786,431
Exper Gain	1/1/2009	15.00	4.00	7,692,968	2,122,597
Exper Gain	1/1/2010	15.00	5.00	70,770,524	16,131,096
Exper Gain	1/1/2011	15.00	6.00	53,537,474	10,497,136
Exper Gain	1/1/2013	15.00	8.00	16,032,441	2,509,267
Exper Gain	1/1/2014	15.00	9.00	58,397,057	8,376,783
Total Credits				$ 258,580,499	$ 48,340,682
Net Total				$ 863,827,707	$ 86,109,495

Different types of amortization bases are as follows:

Abbreviation	Description
Initial Liab	Initial unfunded actuarial accrued liability
Exper Loss	Actuarial experience loss (charge only)
Exper Gain	Actuarial experience gain (credit only)
ENIL (2008)	Eligible net investment loss under the Pension Relief Act of 2010
Amendment	Plan amendment
Assumption	Change in actuarial assumptions
Method	Change in the actuarial cost method, or asset valuation method
Combined	Combined charge base or combined credit base
Offset	Combined and offset charge and credit bases

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Schedule MB, Line 11
Justification for Change in Actuarial Assumptions

Since the prior valuation, the following assumptions have been changed:

- **Non-Disabled Participant Mortality –** RP-2014 Blue Collar Healthy Mortality Table with two-year set forward (separate male and female tables). Prior valuation assumed RP-2000 Combined Blue Collar mortality (separate male and female tables)
- **Contribution Income –** It is assumed that 101,400,000 hours are worked each year at a contribution rate of $1.305 per hour through May 31, 2020 and $1.405 per hour thereafter. (Prior valuation assumed 99,000,000 hours at a rate of $1.205 per hour through May 31, 2019 and $1.305 per hours thereafter)
- **Lump Sum Conversion –** The basis to determine lump sums was updated to 2020 PPA Unisex Combined Mortality Table and 5.75% interest. (Prior valuation used 2019 PPA Unisex Combined Mortality Table and 6.25% interest.)

Based on the results of the 2020 comprehensive experience study, the changes in the actuarial assumptions described above were made to better reflect recent and anticipated Plan experience.

Schedule MB, Line 6
Summary of Plan Provisions

This appendix summarizes the major provisions of the Plan that were reflected in the actuarial valuation. This summary of provisions is not intended to be a comprehensive statement of all provisions of the Plan.

Plan Name	Southern Nevada Culinary and Bartenders Pension Plan
Plan Sponsor	Board of Trustees
EIN / PN	88-6016617 / 001
Effective Date and Most Recent Amendment	The original effective date of the Plan is January 1, 1971. The most recent amendment reflected in this valuation is Amendment #3, which was adopted on March 7, 2018.
Plan Year	The twelve-month period beginning January 1 and ending December 31.
Employers	A participating Employer is any employer or entity that has been accepted for participation in the Plan and that is required to contribute to the Plan pursuant to a collective bargaining agreement or regulations adopted by the Board of Trustees.
Participants	All Employees in Covered Employment participate in the Plan immediately upon entering into Covered Employment.

Pension Credit

A participant receives Past Service Credit for covered employment between January 1, 1964 and January 1, 1971 provided he worked at least 350 hours in 1971 or 350 hours in 1972. Future Service Credits are determined under the following schedule:

Hours Worked in a Plan Year 1971-75	Future Service Credit	Hours of Employment in a Plan Year 1976 and Later	Future Service Credit
1400 & over	1.00	1000 & over	1.00
1050-1399	.75	900-999	.90
700-1049	.50	800-899	.80
350-699	.25	700-799	.70
Under 350	None	600-699	.60
		500-599	.50
		400-499	.40
		300-399	.30
		Under 300	None

Normal Retirement Age

A participant attains Normal Retirement Age at the later of attaining age 65 or the fifth anniversary of an active Participant's Plan participation excluding participation before January 1, 1988 (or the tenth anniversary including participation before January 1, 1988).

Break-In-Service

Completion of less than 300 hours of service in a Plan Year.

Note: For non-vested benefits, cancellation of Pension Credit occurs after the greater of (i) five consecutive Break-in-Service years or (ii) the number of aggregate Plan Years for which the employee has received Past or Future Service Credit.

Regular Pension – Eligibility

Age 62 with at least 5 years of Pension Credit, or age 65 and the tenth anniversary of participation without a Break-in-Service.

Regular Pension – Amount of Benefit

The monthly amount of the Regular Pension for Pension Credits earned on and after January 1, 2016 is determined in accordance with the following schedule:

Hours Worked in Plan Year	Monthly Accumulated Benefit	Hours Worked in Plan Year	Monthly Accumulated Benefit
2000 or more	$37.83	1000-1099	$18.92
1900-1999	35.94	900-999	17.03
1800-1899	34.05	800-899	15.14
1700-1799	32.16	700-799	13.25
1600-1699	30.27	600-699	11.36
1500-1599	28.38	500-599	9.46
1400-1499	26.49	400-499	7.57
1300-1399	24.60	300-399	5.68
1200-1299	22.71	Under 300	None
1100-1199	20.82		

For participants who worked at least 300 hours in 2016 and were not retired as of January 1, 2016, the schedule above also applies to Pension Credits earned between January 1, 1976 and December 31, 2015. Other benefit schedules apply to pre-2016 service for participants who did not work at least 300 hours in 2016.

In addition, the amount of Regular Pension includes $11.00 for each year of Pension Credit accumulated prior to January 1, 1976.

Pensioners are entitled to a pension of not less than $175.00 ($125.00 prior to January 1, 1994) per month even if the scheduled benefit produces a lesser amount. Inactive vested participants are entitled to receive the benefit level in effect at the date of benefit commencement.

Deferred Commencement of Benefits

In the event that pension benefits commence after the first day of the month following an Employee's eligibility to retire for a Regular Pension, the benefit is increased to reflect the greater of (i) the Actuarial Equivalent of the Regular Pension at the initial eligibility for a Regular Pension, and (ii) the additional benefit accrued during the period of service after the initial eligibility date. The increase in the Employee's benefit is computed at the end of each Plan Year following initial eligibility and again at the Employee's Pension Benefit Starting Date. The actuarial equivalent adjustment increase factor equals 1.0% for each month eligibility precedes the Pension Benefit Starting Date for the first 60 months, and 1.5% for each additional month after 60 months.

Early Pension – Eligibility

Age 55 with at least 5 years of Pension Credit.

Early Pension – Amount of Benefit	The calculated Regular Pension reduced by ¾ of one percent for each month the retiring employee is under age 62 but not under age 60, and ½ of one percent for each month under age 60. The $175.00 ($125.00 prior to January 1, 1994) minimum pension does not apply to the Early Pension.
Disability Benefit – Eligibility	Totally and permanently disabled with at least 5 years of Pension Credit and worked in covered employment for at least 300 hours during the year of disability and the prior Plan Year combined.
Disability Benefit – Amount of Benefit	Same as the calculated Regular Pension, commencing immediately. If married, the pension is payable in the 50% Joint and Survivor form of payment. At regular retirement, the pensioner may elect another form of payment.
Vested Benefit	Vesting is provided for participants who have accumulated at least 10 years of Pension Credit (5 years of Pension Credit for employees of the unions or of the Trust). Employees with at least one hour of service on or after January 1, 1988, also vest upon the later of (a) age 65 or (b) the fifth anniversary of commencement of participation in the Plan without a Break-in-Service. Employees with at least one hour of service on or after January 1, 1994 are vested if they have accumulated at least 8 years of Pension Credit. Employees with at least one hour of service on or after January 1, 1997 are vested if they have accumulated at least 5 years of Pension Credit.
Pre-Retirement Death Benefits	*Spouse's Benefit* If a deceased married participant had not retired but had met the service requirements for vesting, his spouse receives a survivor's annuity. The survivor's annuity is payable for life, commencing upon the death of the participant, and the monthly amount is the survivor's portion of the Regular Pension earned through the date of death (based on a 50% Joint and Survivor Annuity). (Prior to January 1, 1994, the survivor annuity was a monthly amount, payable for life, equal to 50% of the benefit the participant would have received had he retired on the Joint and Survivor pension the day before he died. If the participant was under age 55 and vested at the time of death, the benefit to the spouse was deferred until the participant would have been age 55.)
Lump Sum Death Benefit	For active participants with at least one year of Future Service Credit. The amount of benefit is equal to $500.00 for each year of Pension Credit, Past or Future, up to a maximum of $20,000 ($10,000 prior to January 1, 1994). This benefit is payable only if no other death benefit is payable.

Forms of Payment	**Normal Form:** For married participants, retirement benefits are paid in the form of a 50% joint and survivor annuity (with "pop-up" increase feature) unless this form is rejected by a participant. If not rejected, the benefit amount otherwise payable is reduced to reflect the joint and survivor form. If rejected, or if not married, benefits are payable for the life of the participant without reduction. Unmarried participants may elect the joint and survivor annuity as an optional form of payment. **Optional Forms:** *Lump Sum Option* A participant retiring on a Regular Pension who rejects the Joint and Survivor Benefit or is not married may elect to receive up to 50% of the actuarial equivalent of his pension as a lump sum payment and the remaining portion of his benefit as a life annuity or joint and survivor annuity. The actuarial equivalence is based upon 6.50% interest and the 1971 Group Annuity Mortality Table, or the PPA statutory interest rates and mortality table, whichever produces the greater lump sum. The lump sum payment may not exceed $50,000. *Life Annuity* Monthly payment, payable to the participant for life. Payments stop upon the death of the participant. *Qualified Optional Survivor Annuity* A 75% joint and survivor annuity is available to married participants.
Actuarial Equivalence	Benefits under the 50% joint and survivor annuity (with "pop-up" increase feature) are converted from the amount payable under the Life Annuity by a factor equal to 90.0% minus 0.4% for each year that the spouse is younger than the Employee, and plus 0.4% for each year that the spouse is older that the Employee, subject to a maximum factor of 99.0%. Other optional joint forms of benefit for healthy and disabled employees are also converted by means of a formula.
Contribution Rates	Employer contribution rate is $1.305 per hour, effective through May 31, 2020 and $1.405 per hour thereafter.

Changes in Plan Provisions	Employer contribution rate is $1.405 per hour, effective June 1, 2020; prior to June 1, 2020 the contribution rate was $1.305 per hour.

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Schedule MB Attachments
Schedule of Projection of Expected Benefit Payments

Schedule MB, line 8b(1) - Schedule of Projection of Expected Benefit Payments	
Plan Year Beginning January 1	Expected Annual Benefit Payments
2020	$197,219,605
2021	$189,708,286
2022	$200,701,781
2023	$208,244,943
2024	$216,622,094
2025	$223,394,240
2026	$227,918,375
2027	$233,520,499
2028	$235,887,785
2029	$237,377,770

Note

Expected benefit payments assume no future accruals, no future new entrants to the Plan, and experience consistent with the valuation assumptions set forth herein.

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Schedule MB Attachments
Statement by the Enrolled Actuary

Plan Sponsor:	Board of Trustees, Southern Nevada Culinary & Bartenders Pension Plan
EIN:	88-6016617
Plan Number:	001
Plan Name:	Southern Nevada Culinary & Bartenders Pension Plan
Valuation Date:	January 1, 2020
Enrolled Actuary:	Cary Franklin
Enrollment Number:	20-04013

The actuarial assumptions and methods, in combination, represent the enrolled actuary's best estimate of anticipated experience under the plan, subject to the following conditions:

The actuarial valuation, on which the information in this Schedule MB is based, has been prepared in reliance upon the employee and financial data furnished by the plan administrator and the plan's auditor. The enrolled actuary has not made a rigorous check of the accuracy of this information but has accepted it after reviewing it and concluding it is reasonable in relation to similar information furnished in previous years. The amount of contributions shown in Line 3 of Schedule MB was entered in reliance on information provided by the plan's auditor.

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