

2020 Plan Information Worksheet

Status:

Plan Sponsor Information

Plan Sponsor's Name
Auxiliary Services Corporation of
SUNY Cortland

Plan Sponsor's Mailing Address
15 Neubig Road

Foreign

Plan Sponsor's Doing Business As Name

Plan Sponsor's Mailing City, Province, State and ZIP
Cortland NY 13045-2435

Plan Sponsor's Location Address

Foreign

Plan Sponsor's Care Of Name

Plan Sponsor's EIN
15-0548524

Plan Sponsor's Location City, Province, State and ZIP

Plan Sponsor's Phone Number

(607)753-2431

Plan Administrator Information

 Same as Plan Sponsor

Plan Administrator's Name

Plan Administrator's Address

Foreign

Plan Administrator's Care Of Name

Plan Administrator's City, Province, State and ZIP

Plan Administrator's EIN

Plan Administrator's Phone Number

Plan Information

Plan Name
Auxiliary Services Corporation of SUNY Cortland
Defined Contribution Retirement Plan

Business Code
611000

Filing for Plan Year:
2020

DFE Plan

Plan Year
Begins

MM/DD/YYYY
07/01/2020

MM/DD/YYYY
Ends 06/30/2021

Three-digit Plan Number
003

Plan ID

Tax Year
Begins

MM/DD/YYYY
07/01/2020

MM/DD/YYYY
Ends 06/30/2021

EIN for PBGC Forms

Name Control

Effective Date of Plan
07/01/1997

Transmitter Information

Transmitter's TIN
47-5324570

Transmitter Control Code (TCC)
61817

Contact Name
Thomas Whelehan

Transmitter's Name
Steven Mills

Contact Telephone Number
(585)697-9696

Company Name
Insero & Co. CPAs, LLP

Contact E-Mail Address
thomas.whelehan@inserocpa.com

Company Mailing Address

Foreign

2 State Street

Company City, Province, State and ZIP

Rochester NY 14614-

Do NOT File with IRS, DOL or PBGC

Preparer Information

Preparer's Name Preparer's City, Province, State and ZIP

Preparer's Firm Name Preparer's Phone Number

Preparer's Address Foreign

Trust Information

Name of Trust Trust EIN

Name of Trustee or Custodian Trustee's or Custodian's Phone #

Signers, Service Providers and Interested Individuals

Notify Plan Administrator Contact Phone Number

Contact Name E-Mail Address
Renee Sydorowych renee.sydorowych@cortland.edu
Contact ID

Notify Contact Phone Number

Contact Name E-Mail Address
Contact ID

Notify Contact Phone Number

Contact Name E-Mail Address
Contact ID

Notify Contact Phone Number

Contact Name E-Mail Address
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Contact Name E-Mail Address
Contact ID

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

▶ **Complete all entries in accordance with the instructions to the Form 5500.**OMB Nos. 1210-0110
1210-0089**2020****This Form is Open to Public Inspection****Part I Annual Report Identification Information**

For calendar plan year 2020 or fiscal plan year beginning 07/01/2020 and ending 06/30/2021

- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
 a single-employer plan a DFE (specify) _____
- B** This return/report is: the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here.
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)

Part II Basic Plan Information—enter all requested information

| | |
|---|--|
| 1a Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | 1b Three-digit plan number (PN) ▶ 003 |
| | 1c Effective date of plan 07/01/1997 |
| 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) Auxiliary Services Corporation of SUNY Cortland 15 Neubig Road Cortland NY 13045-2435 | 2b Employer Identification Number (EIN) 15-0548524 |
| | 2c Plan Sponsor's telephone number (607) 753-2431 |
| | 2d Business code (see instructions) 611000 |
| | |

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 | | | Renee Sydorowych |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

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

**Form 5500 (2020)
v. 200204**

| | |
|--|---|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN 3c Administrator's telephone number |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN 4d PN |
| 5 Total number of participants at the beginning of the plan year | 5 477 |
| 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) 200 |
| a(2) Total number of active participants at the end of the plan year | 6a(2) 188 |
| b Retired or separated participants receiving benefits..... | 6b 0 |
| c Other retired or separated participants entitled to future benefits | 6c 292 |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d 480 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | 6e 2 |
| f Total. Add lines 6d and 6e | 6f 482 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g 473 |
| h Number of participants who 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 |
| 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2F 2G 2L | |
| 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) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | 9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> 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) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <u>1</u> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> 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)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 07/01/2020 and ending 06/30/2021

| | | |
|--|---|-----|
| A Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | B Three-digit plan number (PN) ▶ | 003 |
|--|---|-----|

| | |
|--|---|
| C Plan sponsor's name as shown on line 2a of Form 5500 Auxiliary Services Corporation of SUNY Cortland | D Employer Identification Number (EIN) 15-0548524 |
|--|---|

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

TIAA-CREF

| (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 |
| 13-1624203 | 69345 | 500888 | 254 | 07/01/2020 | 06/30/2021 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | |
|--|----------|-----------|
| 4 Current value of plan's interest under this contract in the general account at year end | 4 | 2,428,156 |
| 5 Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 6,703,573 |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year **7b** 2,258,373

| | | | |
|--|--------------|---------|--|
| c Additions: (1) Contributions deposited during the year | 7c(1) | 141,102 | |
| (2) Dividends and credits..... | 7c(2) | 0 | |
| (3) Interest credited during the year..... | 7c(3) | 81,731 | |
| (4) Transferred from separate account..... | 7c(4) | 160,705 | |
| (5) Other (specify below)..... ▶ Participant Loan Interest & Loan Principal Repayment | 7c(5) | 3,138 | |
| (6) Total additions | 7c(6) | 386,676 | |

d Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 2,645,049

| | | | |
|---|--------------|---------|--|
| e Deductions: | | | |
| (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | 213,810 | |
| (2) Administration charge made by carrier..... | 7e(2) | | |
| (3) Transferred to separate account..... | 7e(3) | 1,229 | |
| (4) Other (specify below)..... ▶ Fees | 7e(4) | 1,854 | |

(5) Total deductions **7e(5)** 216,893

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 2,428,156

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

| | | |
|---|-----------------|-----------------|
| a Premiums: (1) Amount received | 9a(1) | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) |
| b Benefit charges (1) Claims paid..... | 9b(1) | |
| (2) Increase (decrease) in claim reserves..... | 9b(2) | |
| (3) Incurred claims (add (1) and (2))..... | | 9b(3) |
| (4) Claims charged..... | | 9b(4) |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| (A) Commissions | 9c(1)(A) | |
| (B) Administrative service or other fees | 9c(1)(B) | |
| (C) Other specific acquisition costs..... | 9c(1)(C) | |
| (D) Other expenses | 9c(1)(D) | |
| (E) Taxes..... | 9c(1)(E) | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | |
| (G) Other retention charges..... | 9c(1)(G) | |
| (H) Total retention..... | | 9c(1)(H) |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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 07/01/2020 and ending 06/30/2021

A Name of plan
Auxiliary Services Corporation of SUNY Cortland
Defined Contribution Retirement Plan

B Three-digit plan number (PN) ▶ 003

C Plan sponsor's name as shown on line 2a of Form 5500
Auxiliary Services Corporation of
SUNY Cortland

D Employer Identification Number (EIN)
15-0548524

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
CREF-TTAA-CREF INVESTMENT MGMT, LLC
13-3586142

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

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

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

TIAA-TEACHERS INSURANCE AND ANNUITY
13-1624203

| (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 15 37 38 50 52 | NONE | 18,028 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

**SCHEDULE D
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection.

For calendar plan year 2020 or fiscal plan year beginning 07/01/2020 and ending 06/30/2021

| | | |
|--|---|-----|
| A Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | B Three-digit plan number (PN) ▶ | 003 |
|--|---|-----|

| | |
|--|---|
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 Auxiliary Services Corporation of SUNY Cortland | D Employer Identification Number (EIN) 15-0548524 |
|--|---|

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: TIAA REAL ESTATE

b Name of sponsor of entity listed in (a): TIAA-CREF

| | | |
|---------------------------------------|-------------------------------|---|
| c EIN-PN <u>13-1624203 004</u> | d Entity code <u>P</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>96,921</u> |
|---------------------------------------|-------------------------------|---|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

**SCHEDULE H
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

| | | | | |
|---|---|------------|------------|---|
| For calendar plan year 2020 or fiscal plan year beginning | | 07/01/2020 | and ending | 06/30/2021 |
| A Name of plan | Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | | | B Three-digit plan number (PN) ▶ 003 |
| C Plan sponsor's name as shown on line 2a of Form 5500 | Auxiliary Services Corporation of SUNY Cortland | | | D Employer Identification Number (EIN) 15-0548524 |

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 | |
| b Receivables (less allowance for doubtful accounts): | | |
| (1) Employer contributions | 1b(1) | |
| (2) Participant contributions..... | 1b(2) | |
| (3) Other | 1b(3) | |
| c General investments: | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | |
| (2) U.S. Government securities | 1c(2) | |
| (3) Corporate debt instruments (other than employer securities): | | |
| (A) Preferred | 1c(3)(A) | |
| (B) All other..... | 1c(3)(B) | |
| (4) Corporate stocks (other than employer securities): | | |
| (A) Preferred..... | 1c(4)(A) | |
| (B) Common | 1c(4)(B) | |
| (5) Partnership/joint venture interests | 1c(5) | |
| (6) Real estate (other than employer real property) | 1c(6) | |
| (7) Loans (other than to participants)..... | 1c(7) | |
| (8) Participant loans | 1c(8) | 82,921 |
| (9) Value of interest in common/collective trusts | 1c(9) | |
| (10) Value of interest in pooled separate accounts | 1c(10) | 114,018 |
| (11) Value of interest in master trust investment accounts..... | 1c(11) | |
| (12) Value of interest in 103-12 investment entities | 1c(12) | |
| (13) Value of interest in registered investment companies (e.g., mutual funds) | 1c(13) | 11,015,875 |
| (14) Value of funds held in insurance company general account (unallocated contracts)..... | 1c(14) | 12,977,109 |
| (15) Other..... | 1c(15) | 2,258,373 |
| | | 86,562 |
| | | 96,921 |
| | | 2,428,156 |

| | | (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 | 13,471,187 15,588,748 |
| Liabilities | | | |
| g | Benefit claims payable..... | 1g | |
| h | Operating payables..... | 1h | |
| i | Acquisition indebtedness..... | 1i | |
| j | Other liabilities..... | 1j | |
| k | Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 0 0 |
| Net Assets | | | |
| l | Net assets (subtract line 1k from line 1f)..... | 1l | 13,471,187 15,588,748 |

Part II Income and Expense Statement

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

| | | (a) Amount | (b) Total |
|---------------|--|-----------------|-----------|
| Income | | | |
| a | Contributions: | | |
| (1) | Received or receivable in cash from: (A) Employers..... | 2a(1)(A) | 446,750 |
| | (B) Participants..... | 2a(1)(B) | 330,954 |
| | (C) Others (including rollovers)..... | 2a(1)(C) | 254,623 |
| (2) | Noncash contributions..... | 2a(2) | |
| (3) | Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2) | 2a(3) | 1,032,327 |
| b | Earnings on investments: | | |
| (1) | Interest: | | |
| | (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | |
| | (B) U.S. Government securities..... | 2b(1)(B) | |
| | (C) Corporate debt instruments..... | 2b(1)(C) | |
| | (D) Loans (other than to participants)..... | 2b(1)(D) | |
| | (E) Participant loans..... | 2b(1)(E) | 2,882 |
| | (F) Other..... | 2b(1)(F) | 81,731 |
| | (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | 84,613 |
| (2) | Dividends: (A) Preferred stock..... | 2b(2)(A) | |
| | (B) Common stock..... | 2b(2)(B) | |
| | (C) Registered investment company shares (e.g. mutual funds)..... | 2b(2)(C) | 158,999 |
| | (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | 158,999 |
| (3) | Rents..... | 2b(3) | |
| (4) | Net gain (loss) on sale of assets: (A) Aggregate proceeds..... | 2b(4)(A) | |
| | (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | |
| | (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | 0 |
| (5) | Unrealized appreciation (depreciation) of assets: (A) Real estate..... | 2b(5)(A) | |
| | (B) Other..... | 2b(5)(B) | |
| | (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | 0 |

| | | (a) Amount | (b) Total |
|---|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts..... | 2b(6) | | |
| (7) Net investment gain (loss) from pooled separate accounts..... | 2b(7) | | 6,473 |
| (8) Net investment gain (loss) from master trust investment accounts | 2b(8) | | |
| (9) Net investment gain (loss) from 103-12 investment entities | 2b(9) | | |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) | 2b(10) | | 3,131,072 |
| c Other income | 2c | | |
| d Total income. Add all income amounts in column (b) and enter total..... | 2d | | 4,413,484 |

Expenses

| | | | |
|---|-------|-----------|-----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers..... | 2e(1) | 2,278,420 | |
| (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) | | 2,278,420 |
| 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) | | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Investment advisory and management fees | 2i(3) | | |
| (4) Other..... | 2i(4) | 17,503 | |
| (5) Total administrative expenses. Add lines 2i(1) through (4) | 2i(5) | | 17,503 |
| j Total expenses. Add all expense amounts in column (b) and enter total..... | 2j | | 2,295,923 |

Net Income and Reconciliation

| | | | |
|---|-------|--|-----------|
| k Net income (loss). Subtract line 2j from line 2d..... | 2k | | 2,117,561 |
| l Transfers of assets: | | | |
| (1) To this plan..... | 2l(1) | | |
| (2) From this plan | 2l(2) | | |

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: Inero & Co. CPAs, LLP

(2) EIN: 47-5324570

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

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

Part IV Compliance Questions

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

During the plan year:

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

| | Yes | No | Amount |
|----|-----|----|--------|
| 4a | | X | |

| | Yes | No | Amount |
|--|-----|----|-----------|
| b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) | | 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.) | | 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.) | | X | |
| e Was this plan covered by a fidelity bond? | X | | 2,000,000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | X | |
| g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)..... | X | | |
| j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)..... | | X | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | | X | |
| l Has the plan failed to provide any benefit when due under the plan? | | X | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)..... | | X | |
| n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3..... | | | |

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

| | | |
|--|---|---|
| SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | 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. | <small>OMB No. 1210-0110</small> 2020 This Form is Open to Public Inspection. |
|--|---|---|

For calendar plan year 2020 or fiscal plan year beginning 07/01/2020 and ending 06/30/2021

| | | |
|---|--|------------|
| A Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | B Three-digit plan number (PN) ▶ | <u>003</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 Auxiliary Services Corporation of SUNY Cortland | D Employer Identification Number (EIN) <u>15-0548524</u> | |

| | |
|---------------|----------------------|
| Part I | Distributions |
|---------------|----------------------|

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

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

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
EIN(s): 13-3586142 23-1945930

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

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

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

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

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

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

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

| | |
|-----------------|-------------------|
| Part III | Amendments |
|-----------------|-------------------|

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

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

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

e Contribution rate information (*If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).*)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

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

| | | |
|---|------------|--|
| a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment)..... | 14a | |
| b The plan year immediately preceding the current plan year. <input type="checkbox"/> 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. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)..... | 14c | |

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

| | | |
|--|------------|--|
| a The corresponding number for the plan year immediately preceding the current plan year..... | 15a | |
| b The corresponding number for the second preceding plan year..... | 15b | |

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

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

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

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

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

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

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

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

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

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

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

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

Yes.

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

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

No. Other. Provide explanation _____

Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits

This form is required to be filed under section 6057 of the Internal Revenue Code.
▶ Go to www.irs.gov/Form8955SSA for instructions and the latest information.

PART I Annual Statement Identification Information

For the plan year beginning 07/01/2020, and ending 06/30/2021

- A Check here if plan is a government, church, or other plan that elects to voluntarily file Form 8955-SSA. (See instructions.)
- B Check here if this is an amended registration statement.
- C Check the appropriate box if filing under: Form 5558 Automatic extension
 Special extension (enter description) _____

PART II Basic Plan Information - enter all requested information

| | |
|--|-----------------------------------|
| 1a Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | 1b Plan Number (PN) 003 |
|--|-----------------------------------|

Plan Sponsor Information

| | |
|--|--|
| 2a Plan sponsor's name Auxiliary Services Corporation of SUNY Cortland | 2b Employer Identification Number (EIN) 15-0548524 |
| 2c Trade name (if different from plan sponsor name) | 2d Plan sponsor's phone number (607) 753-2431 |

2e In care of name

| | | | |
|---|----------------------------|-------------------------------|----------------------------------|
| 2f Mailing address (room, apt., suite no. and street, or P.O. box) 15 Neubig Road | 2g City Cortland | 2h State NY | 2i ZIP code 13045-2435 |
| 2j Foreign province (or state) | 2k Foreign country | 2l Foreign postal code | |

Plan Administrator Information

| | | | |
|---|--|-------------------------------|--------------------|
| 3a Plan administrator's name (if other than plan sponsor) Same | 3b Employer Identification Number (EIN) | | |
| 3c In care of name | 3d Plan administrator's phone number | | |
| 3e Mailing address (room, apt., suite no. and street, or P.O. box) | 3f City | 3g State | 3h ZIP code |
| 3i Foreign province (or state) | 3j Foreign country | 3k Foreign postal code | |

4 If the name or EIN of the **plan administrator** has changed since the last return filed for this plan, enter the name and EIN from the last filed return:
Plan administrator's name _____ EIN _____

5 If the name or EIN of the **plan sponsor** has changed since the last return filed for this plan, enter the name, EIN, and plan number from that return:
Plan sponsor's name _____ EIN _____ Plan Number (PN) _____

| | |
|---|--------------|
| 6a Participants who separated with a deferred vested benefit required to be reported on this Form 8955-SSA | 6a |
| b Participants who separated with a deferred vested benefit voluntarily reported on this Form 8955-SSA in the same year as the separation occurred | 6b 33 |
| 7 Total number of participants reported on lines 6a and 6b | 7 33 |

8 Did the plan administrator provide an individual statement to each participant required to receive a statement? Yes No

Under penalties of perjury, I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | | |
|--------------------|---------------------------|-------------|---------------------------------|-------------|
| Sign Here ▶ | Signature of plan sponsor | Date signed | Signature of plan administrator | Date signed |
|--------------------|---------------------------|-------------|---------------------------------|-------------|

| | | |
|--|--------------------|-------------------|
| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
|--|--------------------|-------------------|

PART III Participant Information - enter all requested information

- 9 Enter one of the following Entry Codes in column (a) for each separated participant with deferred vested benefits who:
- Code A** — has not previously been reported.
 - Code B** — has previously been reported under the above plan number, but whose previously reported information requires revisions.
 - Code C** — has previously been reported under another plan, but who will be receiving benefits from the plan listed above instead.
 - Code D** — has previously been reported under the above plan number, but whose benefits have been paid out or who is no longer entitled to those deferred vested benefits.

| Use with entry code "A", "B", "C", or "D" | | | | | Use with entry code "A" or "B" | | | | Entry code "C" only | | |
|---|---|---|------|-----------|--------------------------------|--|--------------------------|---|--|-------------------------------------|-----------------------------------|
| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | (g) Defined contribution plan — total value of account | | |
| A | XXX-XX-1506 | JENNIFER | | FOSTER | | A | A | | 288 | | |
| A | XXX-XX-5772 | JOSEPH | G | POST | | A | A | | 17,939 | | |
| A | XXX-XX-6474 | PATRICK | | CALL | | A | A | | 1,509 | | |
| A | XXX-XX-1569 | MATTHEW | | WOOD | | A | A | | 2,242 | | |
| A | XXX-XX-1452 | LOGAN | | STAGE | | A | A | | 127 | | |
| A | XXX-XX-8865 | ROBERT | | SAGER | | A | A | | 107,480 | | |
| A | XXX-XX-1767 | MICHAEL | | HAPGOOD | | A | A | | 154 | | |
| A | XXX-XX-7037 | OCEAN | | LIBBEY | | A | A | | 91 | | |
| A | XXX-XX-7858 | ANNETTE | E | OHARA | | A | A | | 255,334 | | |
| A | XXX-XX-2185 | BRANDY | | WRIGHT | | A | A | | 13,769 | | |

| | | |
|--|--------------------|-------------------|
| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
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PART III Participant Information - enter all requested information

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| Use with entry code "A", "B", "C", or "D" | | | | | Use with entry code "A" or "B" | | | | Entry code "C" only | | |
|---|---|---|------|-------------|--------------------------------|--|--------------------------|---|--|-------------------------------------|-----------------------------------|
| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | (g) Defined contribution plan — total value of account | | |
| A | XXX-XX-0693 | WILLIAM | C | EPP | | A | A | | 51,693 | | |
| A | XXX-XX-2141 | CONNIE | | LIEB | | A | A | | 187 | | |
| A | XXX-XX-1970 | SHAWN | | BARTEE | | A | A | | 68 | | |
| A | XXX-XX-2056 | VINCENT | C | MARSHALL JR | | A | A | | 1,126 | | |
| A | XXX-XX-6633 | ERIK | | LUCAS | | A | A | | 2,807 | | |
| A | XXX-XX-0046 | KELLY | | WALSH | | A | A | | 47 | | |
| A | XXX-XX-7063 | MISTY | | WEST | | A | A | | 34 | | |
| A | XXX-XX-5497 | ASHLEY | | COOPER | | A | A | | 1,665 | | |
| A | XXX-XX-8167 | CATHY | L | LITTLE | | A | A | | 37,691 | | |
| A | XXX-XX-7919 | SAMANTHA | | STANDISH | | A | A | | 66 | | |

| | | |
|--|--------------------|-------------------|
| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
|--|--------------------|-------------------|

PART III Participant Information - enter all requested information

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| Use with entry code "A", "B", "C", or "D" | | | | | Use with entry code "A" or "B" | | | | Entry code "C" only | | |
|---|---|---|------|----------------|--------------------------------|--|--------------------------|---|--|-------------------------------------|-----------------------------------|
| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | (g) Defined contribution plan — total value of account | | |
| A | XXX-XX-2562 | SHERRI | L | WALRAD | | A | A | | 5,373 | | |
| A | XXX-XX-8850 | ALAN | | WILLIAMS | | A | A | | 69 | | |
| A | XXX-XX-8285 | MELISSA | | MERA FERNANDEZ | | A | A | | 63 | | |
| A | XXX-XX-0544 | JASON | | MARSHALL | | A | A | | 8,791 | | |
| A | XXX-XX-1496 | MARIE | T | MONASTRA | | A | A | | 9,118 | | |
| A | XXX-XX-4461 | SHANE | | WILLIS | | A | A | | 449 | | |
| A | XXX-XX-5312 | GARY | | INMAN | | A | A | | 60,580 | | |
| A | XXX-XX-5816 | CARL | | BUMP | | A | A | | 65 | | |
| A | XXX-XX-5407 | ADRIEL | | ALBRO | | A | A | | 44,405 | | |
| A | XXX-XX-3397 | SAMUEL | J | COFFEY | | A | A | | 350,913 | | |

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|--|--------------------|-------------------|
| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
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PART III Participant Information - enter all requested information

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| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | | |
| A | XXX-XX-6693 | VANESSA | | HAMILTON | | A | A | | 15,276 | |
| A | XXX-XX-4459 | TIANNA | | ENGLISH | | A | A | | 18 | |
| A | XXX-XX-4367 | TANA | | ARMITSTEAD | | A | A | | 142 | |
| D | XXX-XX-4509 | JEFFREY | | REISMAN | | | | | | |
| D | XXX-XX-0024 | MARGARET | | SWEENEY | | | | | | |
| D | XXX-XX-8469 | MICHELE | K | BRACKIN | | | | | | |
| D | XXX-XX-7228 | RACHAEL | N | HALE | | | | | | |
| D | XXX-XX-7261 | ALISON | | WRIGHT | | | | | | |
| D | XXX-XX-9932 | SANDRA | | REAKES | | | | | | |
| D | XXX-XX-1827 | TODD | | UPDIKE | | | | | | |

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| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
|--|--------------------|-------------------|

PART III Participant Information - enter all requested information

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| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | | |
| D | XXX-XX-6946 | JENNIFER | | PARKER-SMITH | | | | | | |
| D | XXX-XX-4058 | KELLY | | HUNNEYMAN | | | | | | |
| D | XXX-XX-5001 | BRIAN | | TIERNEY | | | | | | |
| D | XXX-XX-2902 | MARTIN | J | KRETZ | | | | | | |
| D | XXX-XX-1798 | THOMAS | | KIERNAN | | | | | | |
| D | XXX-XX-6857 | VICTORIA | | MAIONE | | | | | | |
| D | XXX-XX-8921 | SANDRA | M | NATALE | | | | | | |
| D | XXX-XX-4232 | JOHN | H | MARVIN | | | | | | |
| D | XXX-XX-9457 | JOSHUA | A | BLAKE | | | | | | |
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| Name of plan Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | Plan Number 003 | EIN 15-0548524 |
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PART III Participant Information - enter all requested information

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|---|---|---|------|-----------|--------------------------------|--|--------------------------|---|--|-------------------------------------|-----------------------------------|
| (a) Entry Code | (b) Full Social Security Number (or "FOREIGN") | (c) Name of Participant (See instructions.) | | | | Enter code for nature and form of benefit | | Amount of vested benefit | | (h) Previous sponsor's EIN | (i) Previous plan number |
| | | First name | M.I. | Last name | ✓ | (d) Type of annuity | (e) Payment frequency | (f) Defined benefit plan — periodic payment | (g) Defined contribution plan — total value of account | | |
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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.

File With IRS Only

Part I Identification

| A Name of filer, plan administrator, or plan sponsor (see instructions) Auxiliary Services Corporation of SUNY Cortland Number, street, and room or suite no. (If a P.O. box, see instructions) 15 Neubig Road City or town, state, and ZIP code Cortland NY 13045-2435 | B Filer's identifying number (see instructions) Employer identification number (EIN) (9 digits XX-XXXXXXX) 15-0548524 Social security number (SSN) (9 digits XXX-XX-XXXX) | | | | | | | | | | | | | | | | | | | |
|---|---|-------------------|------|--|--|----|----|------|--|--|---|---|---|--|--|---|----|------|--|--|
| C <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 60%;">Plan name</th> <th colspan="4" style="text-align: center;">Plan year ending—</th> </tr> <tr> <th style="width: 5%;">MM</th> <th style="width: 5%;">DD</th> <th colspan="2" style="width: 15%;">YYYY</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: none;">Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan</td> <td style="border-bottom: none;">0</td> <td style="border-bottom: none;">0</td> <td colspan="2" style="border-bottom: none;">3</td> </tr> <tr> <td style="border-top: none;"></td> <td style="border-top: none;">6</td> <td style="border-top: none;">30</td> <td colspan="2" style="border-top: none;">2021</td> </tr> </tbody> </table> | Plan name | Plan year ending— | | | | MM | DD | YYYY | | Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | 0 | 0 | 3 | | | 6 | 30 | 2021 | | |
| Plan name | | Plan year ending— | | | | | | | | | | | | | | | | | | |
| | MM | DD | YYYY | | | | | | | | | | | | | | | | | |
| Auxiliary Services Corporation of SUNY Cortland Defined Contribution Retirement Plan | 0 | 0 | 3 | | | | | | | | | | | | | | | | | |
| | 6 | 30 | 2021 | | | | | | | | | | | | | | | | | |

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 I, C above.
- 2 I request an extension of time until 4 / 15 / 2022 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 4 / 15 / 2022 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 ▶