Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for:
- ☐ a multiemployer plan
- ☒ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☐ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
THE AFFILIATED PHYSICIANS & EMPLOYERS HEALTH PLAN

1b Three-digit plan number (PN) ▶ 510

1c Effective date of plan 01/01/2012

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)
AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

3131 PRINCETON PIKE
BUILDING 5, SUITE 110
LAWRENCEVILLE, NJ 08648

2b Employer Identification Number (EIN)
45-6416517

2c Plan Sponsor's telephone number
609-890-1500

2d Business code (see instructions)
524140

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	02/18/2025	BRIAN HOFMEISTER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/18/2025	BRIAN HOFMEISTER
	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

3a Plan administrator's name and address ☐ Same as Plan Sponsor

CONCORD MANAGEMENT RESOURCES

PO BOX 369
CHESTER, NJ 07930

3b Administrator's EIN
82-2339246

3c Administrator's telephone number
908-293-6101

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**	0
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)**	0
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	0
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
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:

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

4A 4T

9a Plan funding arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☒ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☒ Trust
- **(4)** ☐ General assets of the sponsor

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

a Pension Schedules

- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** ☐ **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 158827974

SCHEDULE C (Form 5500)	Service Provider 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.**	**2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
THE AFFILIATED PHYSICIANS & EMPLOYERS HEALTH PLAN

B Three-digit plan number (PN) ▶ 510

C Plan sponsor's name as shown on line 2a of Form 5500
AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

D Employer Identification Number (EIN)
45-6416517

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

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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)

AAJ TECHNOLOGIES

500 W CYPRESS CREEK RD
SUITE 570
FORT LAUDERDALE, FL 33309

65-0762524

(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?
23	NONE	60000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

CHRISTOPHER E. CODELUCI

19670 BEACH ROAD
#522
JUPITER, FL 33469

(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	15041	Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CONCORD MANGEMENT RESOUCRES

P.O. BOX 369
CHESTER, NJ 07930

82-2339246

(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?
14	NONE	374735	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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)

DFL GROUP

PO BOX 6
OCEANPORT, NJ 07757

22-3776491

(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	122847	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

GENOVA BURNS, LLC

494 BROAD STREET
NEWARK, NJ 07102

22-2940404

(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	508887	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

NAGEL RICE, LLP

103 EISENHOWER PARKWAY
SUITE 103
ROSELAND, NJ 07068

22-2665216

(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	7132	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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)

LAW FIRM OF BRIAN W. HOFMEISTER LLC

3132 PRINCETON PIKE
SUITE 110
LAWRENCEVILLE, NJ 08648

47-2669742

(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	314953	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

MAZARS USA LLP

135 WEST 50TH STREET
NEW YORK, NY 10020

13-1459550

(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	83187	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

MCMANIMON, SCOTLAND & BAUMANN LLC

75 LIVINGSTON AVENUE
ROSELAND, NJ 07068

22-2837091

(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	112538	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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)

DAVIES ACTUARIAL AUDIT & CONSULTING

5550 PEACHTREE PARKWAY
SUITE 600
PEACHTREE CORNERS, GA 30092

58-2512336

(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 16	NONE	79389	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [X]

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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(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 I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
THE AFFILIATED PHYSICIANS & EMPLOYERS HEALTH PLAN

B Three-digit plan number (PN) ▶ 510

C Plan sponsor's name as shown on line 2a of Form 5500
AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

D Employer Identification Number (EIN)
45-6416517

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	3017468	4510115
b	Total plan liabilities	1b	1622783	1505388
c	Net plan assets (subtract line 1b from line 1a)	1c	1394685	3004727
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable:			
	(1) Employers	2a(1)		
	(2) Participants	2a(2)		
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	2b		
c	Other income	2c	2050837	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		2050837
e	Benefits paid (including direct rollovers)	2e	-756143	
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Administrative service providers (salaries, fees, and commissions)	2h	1196938	
i	Other expenses	2i		
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		440795
k	Net income (loss) (subtract line 2j from line 2d)	2k		1610042
l	Transfers to (from) the plan (see instructions)	2l		

3 **Specific Assets:** If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	
c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Compliance Questions

4 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	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		5000000
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 at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	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? ..... [X] Yes [ ] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year 0.

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 _____.

NOTES FOR FORVIS MAZARS

I. INITIAL EXAMINATION ORDERED BY THE OFFICE OF THE UNITED STATES TRUSTEE

DEBTOR

Affiliated Physicians and Employers Master Trust (the "**Debtor**" or "**Master Trust**") is a self-insured multiple employer welfare arrangement ("**MEWA**") that was formerly registered with New Jersey Department of Banking and Insurance ("**NJ DOBI**") as required by the provisions of New Jersey's **MEWA** statute, N.J.S.A. 17B:27C-1 *et seq*. On or about May 21, 2021 the **Debtor** filed for bankruptcy protection under Subchapter V of Chapter 11 of the Bankruptcy Code, Case No. 21-14286 and assigned to the Office of the United States Trustee, the Honorable Michael B. Kaplan.

On May 25, 2021, the Office of the United States Trustee appointed **Brian W. Hofmeister** to serve as the Subchapter V Trustee (the "**Trustee**").

EXPANSION OF POWERS BY THE BANKRUPTCY COURT FOR THE SUBCHAPTER V TRUSTEE

Pursuant to Orders issued by the United States Bankruptcy Court, the Honorable Michael B. Kaplan, Chief Judge (hereafter "**Judge Kaplan** or **The Court**"), dated November 15, 2021, the "*Expansion of Powers Order*", and the March 21, 2022 Order confirming the **Debtor's** SubChapter V Plan for Liquidation pursuant to 11 U.S.C. §1191(a), referred to as the "*Confirmation Order*", the United States Bankruptcy Court expanded the **Trustee's** powers and authority to conduct an examination as to the underlying cause(s) of the insolvency of **APEMT** (the "**Debtor**") and to identify any potential claims or causes of action that could be pursued on behalf of the **Debtor's** estate.

PERIOD COVERED BY TRUSTEE'S EXAMINATION

Judge Kaplan's "*Expansion of Powers and Confirmation Orders*" directed the **Trustee** to complete the examination of the **Debtor** from the period of January 1, 2016 through December 31, 2020 (the "**Exam Period**") and to analyze the financial and operational conditions of the **Debtor** leading up to the bankruptcy filing May 25, 2021.

EXAMINATION PROCEDURES EMPLOYED

The **Exam Period** of five (5) years was requested by the Office of the United States Trustee to determine if the **Debtor's** financial impairment at year-end 2020 was caused by the additional medical services required by enrollees due to the Covid-19 Pandemic or was **APEMT/Debtor** in an impaired financial condition prior to March 2020.

This Examination included a review and analysis of the **APEMT/Debtor's** governance, operations, the manner in which its business was conducted during the examination period, and

a determination of the **APEMT/Debtor's** financial condition year end for each of the years previously identified.

All phases of the Examination were conducted to determine compliance with generally accepted statutory accounting standards, and with the applicable insurance laws and regulations promulgated by the State of New Jersey, specifically **NJSA 17B:27C-1**, et seq. and U.S. Department of Labor and the Employee Retirement Income Security Act of 1974 ("ERISA").

Incorporated into the team's Examination procedures was a review of the **Debtor's** actuarial certifications and rate filings issued by **APEMT/Debtor's** consulting actuaries, Windsor Strategy Partners, LLC ("**Windsor**") for each of the years examined.

COMPLIANCE WITH ACTUARIAL STANDARDS OF PRACTICE

Merlinos Actuaries Consultants, a Davies Company, completed their examination in accordance with the Actuarial Standards of Practice ("ASOPs"), The two ASOP's that are most applicable to this bankruptcy analysis would be *ASOP 5 - Incurred Health and Disability Claims* and *ASOP 8 - Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits*.

EXAMINATION PROCEDURES EMPLOYED

The **Exam Period** of five (5) years was requested by the Office of the United States Trustee to determine if the **Debtor's** financial impairment at year-end 2020 was caused by the additional medical services required by enrollees due to the Covid-19 Pandemic or was **APEMT/Debtor** in an impaired financial condition prior to March 2020.

This Examination included a review and analysis of the **APEMT/Debtor's** governance, operations, the manner in which its business was conducted during the examination period, and a determination of the **APEMT/Debtor's** financial condition year end for each of the years previously identified.

All phases of the Examination were conducted to determine compliance with generally accepted statutory accounting standards, and with the applicable insurance laws and regulations promulgated by the State of New Jersey, specifically **NJSA 17B:27C-1**, et seq. and U.S. Department of Labor and the Employee Retirement Income Security Act of 1974 ("ERISA").

Incorporated into the team's Examination procedures was a review of the **Debtor's** actuarial certifications and rate filings issued by **APEMT/Debtor's** consulting actuaries, Windsor Strategy Partners, LLC ("**Windsor**") for each of the years examined.

CAUSE OF THE DEBTOR'S FINANCIAL IMPAIRMENT

Merlinos and Associates ("**M&A**") identified in their examination report, that **Windsor** had three (3) rating deficiencies in their methodologies in setting rates for the **Debtor** from 2016 through 2020. Specifically, the rating deficiencies discussed in detailed in the **M&A** examination report **Exhibit 1** are:

1. Use of medical trend rates that were too low;
2. Consistent unfavorable development of incurred claim estimates; and

3. Rating methodology not adjusting for changes in average contract size

RECOMMENDATIONS FROM THE TRUSTEE'S EXAMINATION REPORT

1. The Examination team recommends the Title XI, SubChapter V Trustee, on behalf of the **Debtor** pursue a cause of action against Windsor Strategy Partners, LLC. ("**Windsor**") for the reasons identified in the **M&A** Examination Report.

2. The Title XI, Subchapter V Trustee shall consider action against the public accounting firm Withum, Smith & Brown ("**Withum**") for the following:
   a. Not verifying Board approval for the **EANJ's** amended ***Capitalization and Compensation Agreement Amendments*** executed in 2012 and 2016**;**
   b. Not disclosing to the **Board,** the **ERISA** violations in the original ***Capitalization and Compensation Agreement*** executed in 2011, Amendments in 2012 and 2016; and
   c. Not reporting in the 2019 and 2020 Audited Financial Statements the *Marketing Fee Reconciliation* between **EANJ** and the **Debtor** was not completed.

II. IMPLEMENTATION OF THE CONFIRMED PLAN BY THE DEBTOR ("APEMT")

Pursuant to the Bankruptcy *Confirmation Order*, **APEMT** was also obligated to "seek relief from the State Superior Court pursuant to N.J. Stat. § 17B:27C-11 of the MEWA Act and its related provisions (the "**State Court Proceeding**") for the liquidation and dissolution of the **Debtor** under the supervision of the State Superior Court in the county in which the self-funded multiple employer welfare arrangement has it principal office. The **Debtor's** principal office is located in Morris County, New Jersey.

APPOINTMENT OF INDEPENDENT RECEIVER BY STATE SUPERIOR COURT

On November 10, 2022, the Honorable Frank J. DeAngelis, J.S.C., in the Superior Court of New Jersey, Law Division of Morris County, issued the following judgment regarding the Liquidation and Dissolution of the **Debtor/APEMT**:

- Appointed Brian W. Hofmeister as **Independent Receiver** to oversee the dissolution and liquidation of **APEMT** in accordance with New Jersey **MEWA** statute *17B:27C-11 Rehabilitation, Liquidation, Conservation, Dissolution*;
- Authorized the **Independent Receiver** to continue to execute **APEMT's** Bankruptcy Plan;
- Authorized the **Independent Receiver** to take all action necessary to enact and comply with the Plan and Confirmation Order entered in **APEMT's** Bankruptcy Case;
- "So Authorized" the relief granted in the Plan and Confirmation Order including, but not limited to, **APEMT's** Post-Confirmation Operations;
- Authorized the **Independent Receiver** to continue pursuing claims on behalf of the APEMT as set forth in the Bankruptcy Court's "*Expansion of Powers and Confirmation*

Orders";

- Authorized the **Independent Receiver** and **APEMT** (respectively) to retain attorneys, consultants, accountants, and other specialists as necessary, and pay those professionals from **APEMT's** assets;
- Authorized the waiver of any Board requirements for the **Independent Receiver**;
- Authorized the Independent Receiver to submit an Interim Report to the State Superior Court, Morris County on a quarterly basis; and
- Such other relief that the State Superior Court may deem equitable.

III. STATUS DEBTOR'S PROFESSIONAL LIABILITY CLAIMS

SETTLEMENT WITH WINDSOR STRATEGY PARTNERS, LLC. ("WINDSOR")

On August 5, 2024, the Honorable Frank J. DeAngelis, P.J., CH, entered an Order approving the Confidential Settlement Agreement and Release, and granting the related relief ("**Motion**") between the **Independent Receiver** and **Windsor** pending in the Superior Court of New Jersey, Chancery Division, Morris County.

STATUS OTHER PROFESSIONAL LIABILITY CLAIMS

After conducting an in depth investigation, the **Trustee/Receiver** and his professionals have determined that there are no actionable professional liability claims to pursue against Withum, Smith & Brown ("**Withum**") who served as **APEMT's** public accounting firm from 2016 through 2021.

IV. COMMUNICATION WITH DEPARTMENT OF LABOR ("DOL")

Mr. Hofmeister, serving as the Subchapter V Trustee and Independent Receiver for the Debtor ("**APEMT**"), conducted ongoing conference calls with the Department of Labor ("**DOL**") to discuss the financial condition of **APEMT**.

DOL also received a copy of the Subchapter V Trustee's Examination Report and **DOL** continues to receive the Independent Receiver's quarterly Interim Reports submitted to the Superior Court of New Jersey, Morris County.

NOTICE FROM U.S. DEPARTMENT OF LABOR

On November 21, 2023 the U.S. Department of Labor ("**DOL**") sent to Brian W. Hofmeister, the Court appointed **Independent Receiver** for **APEMT,** a letter that the **DOL** had concluded its investigation of *The Affiliated Physicians & Employers Health Plan* (the "**Plan**") pursuant to the Employee Retirement Income Security Act.

In their letter, **DOL** planned to take no further action at this time against the **APEMT Plan**. **DOL** advised that its decision is binding on the **DOL** only, and does not prevent another individual or governmental agency from taking action.

Plan Name: The Affiliated Physicians and Employers Health Plan
EIN: 45-6416517
PN: 510

The Affiliated Physicians and Employers Health Plan previously provided welfare benefits to employees of participating employers. 2021 was the last year those employees were covered under this welfare arrangement. Starting in 2022 there were still some claims and assets that needed to be paid. However, there were no longer employees covered and no participating employers to report. We're filing this return in accordance with the filing instructions as laid out in the Form 5500 instructions. We will continue to file returns until the plan assets are completely paid out and the assets are zero for which a final Form 5500 will be filed.