

<p style="text-align: center;"><b>Form 5500</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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).</p> <p style="text-align: center;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 2em; font-weight: bold; text-align: center;">2023</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
---	---	---

**Part I Annual Report Identification Information**  
 For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

**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**

<p><b>1a</b> Name of plan <u>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> 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) <u>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</u></p> <p><u>3440 KOSSUTH ST</u> <u>LAFAYETTE, IN 47905-4714</u></p>	<p><b>1c</b> Effective date of plan <u>10/31/1968</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>23-7067814</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>765-447-8803</u></p> <p><b>2d</b> Business code (see instructions) <u>525100</u></p>

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

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

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/09/2025	ERIK MILLER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	6095
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ..... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	5648
	<b>6a(2)</b>	5927
	<b>6b</b>	404
	<b>6c</b>	
	<b>6d</b>	6331
	<b>6e</b>	
	<b>6f</b>	6331
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	

**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:  
 4B 4D 4E 4F 4L 4Q 4A

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(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)

<b>a Pension Schedules</b>		<b>b General Schedules</b>	
(1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)	
(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)	
(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>  1  </u>	
(4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____		(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)	
(5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)		(5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)	
		(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)	

---

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

---

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

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

---

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

**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 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

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

<b>A</b> Name of plan <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>		<b>D</b> Employer Identification Number (EIN) <b>23-7067814</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**THE UNION LABOR LIFE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>13-1423090</b>	<b>69744</b>	<b>SL 10249</b>	<b>5922</b>	<b>03/01/2023</b>	<b>02/29/2024</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

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

(b) 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.

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

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

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

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

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

**b** Balance at the end of the previous year ..... **7b**

**c** Additions: (1) Contributions deposited during the year ..... **7c(1)**  
 (2) Dividends and credits ..... **7c(2)**  
 (3) Interest credited during the year ..... **7c(3)**  
 (4) Transferred from separate account..... **7c(4)**  
 (5) Other (specify below) ..... **7c(5)**  
 ▶

(6) Total additions ..... **7c(6)**

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

**e** Deductions:  
 (1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**  
 (2) Administration charge made by carrier ..... **7e(2)**  
 (3) Transferred to separate account..... **7e(3)**  
 (4) Other (specify below) ..... **7e(4)**  
 ▶

(5) Total deductions ..... **7e(5)**

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1890792
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

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. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection.</b>
--	--	---

For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

<b>A</b> Name of plan <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>	<b>D</b> Employer Identification Number (EIN) <b>23-7067814</b>	

**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

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

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

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

---

---

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

---

---

---

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

---

---

---

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

---

---

---

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

---

---

---

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

---

---

---

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

---

---

---

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

---

---

---

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

---

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

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

ANTHEM INSURANCE COMPANIES, INC.

35-0781558

(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?
12 13 15 49 62	NONE	2665008	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

HARTNETT REYES-JONES LLC

4399 LACLEDE AVE  
ST. LOUIS, MO 63108

(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 50	NONE	133400	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MICHAEL LEDBETTER, LLC

03-0599899

(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 50	NONE	123846	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

S. C. MILLER & CO. INC

35-1820020

(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 50	NONE	2656644	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AMALGAMATED

30 NORTH LASALLE STREET, 38TH FLOOR  
CHICAGO, IL 60602

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	9906	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FORVIS MAZARS, LLP

44-0160260

(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 50	NONE	77005	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

ROMOLO & ASSOCIATES

37-1077733

(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 50	NONE	73488	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LEGACY PROFESSIONALS LLP

32-0043599

(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 50	NONE	6395	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DOCUSTREAM

14860 WICKS BLVD  
SAN LEANDRO, CA 94577

(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?
15 50	NONE	35832	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

BARINGS

20-5578089

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	128282	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MARQUETTE ASSOCIATES

36-3485298

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	30000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NATIONAL INVESTMENT SERVICES, INC.

39-1774284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	212326	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

UNITED ACTUARIAL SERVICES

35-1369500

(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 50	NONE	68850	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

HINES & ASSOCIATES

115 EAST HIGHLAND AVENUE  
ELGIN, IL 60120

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	488124	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

IFM GLOBAL INFRASTRUCTURE FUND

98-0569684

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 40 52	NONE	127153	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

THE UNION LABOR LIFE INSURANCE COMP

13-1423090

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	210516	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(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.

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>► File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
--	--	--

For calendar plan year 2023 or fiscal plan year beginning <b>11/01/2023</b> and ending <b>10/31/2024</b>	
<b>A</b> Name of plan <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>	<b>B</b> Three-digit plan number (PN) <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>INDIANA STATE COUNCIL OF ROOFERS TRUST FOR HEALTH AND WELFARE</b>	<b>D</b> Employer Identification Number (EIN) <b>23-7067814</b>

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

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

		(a) Beginning of Year	(b) End of Year
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>		211005
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	8889526	9420389
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	2185513	1175549
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	37177114	52158864
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	11639217	12322852
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	41154782	54258474
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>	115168066	120025400

<b>1d</b> Employer-related investments:		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	216214218	249572533
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>	1446185	1955185
<b>h</b> Operating payables .....	<b>1h</b>		
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>	74451	
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	1520636	1955185
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	214693582	247617348

**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.

<b>Income</b>		<b>(a)</b> Amount	<b>(b)</b> Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>	80631713	
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	5752677	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		86384390
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>		
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		0
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>	4748622	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		4748622
<b>(3)</b> Rents .....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>	18945867	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts.....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts.....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities.....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	<b>2b(10)</b>		
<b>c</b> Other income.....	<b>2c</b>		-694899
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	<b>2d</b>		109383980

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	<b>2e(1)</b>		
(2) To insurance carriers for the provision of benefits.....	<b>2e(2)</b>	1959715	
(3) Other.....	<b>2e(3)</b>	70007451	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		71967166
<b>f</b> Corrective distributions (see instructions).....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	<b>2g</b>		
<b>h</b> Interest expense.....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	<b>2i(1)</b>		
(2) Contract administrator fees.....	<b>2i(2)</b>	2656644	
(3) Recordkeeping fees.....	<b>2i(3)</b>		
(4) IQPA audit fees.....	<b>2i(4)</b>		
(5) Investment advisory and investment management fees.....	<b>2i(5)</b>	774389	
(6) Bank or trust company trustee/custodial fees.....	<b>2i(6)</b>		
(7) Actuarial fees.....	<b>2i(7)</b>	68850	
(8) Legal fees.....	<b>2i(8)</b>	257246	
(9) Valuation/appraisal fees.....	<b>2i(9)</b>		
(10) Other trustee fees and expenses.....	<b>2i(10)</b>		
(11) Other expenses.....	<b>2i(11)</b>	735919	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		4493048
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	<b>2j</b>		76460214

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		32923766
<b>l</b> Transfers of assets:			
(1) To this plan.....	<b>2l(1)</b>		
(2) From this plan.....	<b>2l(2)</b>		

**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: FORVIS MAZARS, LLP

(2) EIN: 44-0160260

**d** The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1)  This form is filed for a CCT, PSA, DCG 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. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
<b>a</b> 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.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

**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.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> 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 \_\_\_\_\_.



# **Indiana State Council of Roofers Health and Welfare Fund**

EIN: 23-7067814    PN: 501

## **Independent Auditor's Report, Financial Statements, and Supplemental Schedules**

October 31, 2024 and 2023



**Indiana State Council of Roofers  
Health and Welfare Fund  
Contents  
October 31, 2024 and 2023**

---

**Independent Auditor’s Report**..... 1

**Financial Statements**

    Statements of Net Assets Available for Benefits..... 4

    Statements of Changes in Net Assets Available for Benefits ..... 5

    Statements of Plan’s Benefit Obligations ..... 6

    Statements of Changes in Plan’s Benefit Obligations..... 7

    Notes to Financial Statements ..... 8

**Supplemental Schedules**

    Schedule H, Line 4i - Schedule of Assets (Held at End of Year)..... 17

    Schedule H, Line 4j - Schedule of Reportable Transactions ..... 18

    Schedule of Realized Gains (Losses) on Securities Sold..... 19

    Financial Highlights ..... 20

    Administrative Expenses ..... 21

    Claims Paid ..... 22

    Five Year Summary of Operations..... 23

## Independent Auditor's Report

Board of Trustees and Plan Management  
Indiana State Council of Roofers Health and Welfare Fund  
Lafayette, Indiana

### **Opinion**

We have audited the financial statements of Indiana State Council of Roofers Health and Welfare Fund, an employee benefit plan subject to the *Employee Retirement Income Security Act of 1974* (ERISA), which comprise the statements of net assets available for benefits and of plan benefit obligations as of October 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of Indiana State Council of Roofers Health and Welfare Fund as of October 31, 2024 and 2023, and the changes in its net assets available for benefits and plan benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

### **Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Indiana State Council of Roofers Health and Welfare Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Indiana State Council of Roofers Health and Welfare Fund's ability to continue as a going concern within one year after the date that these financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

### ***Auditor's Responsibilities for the Audit of the Financial Statements***

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

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

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

### ***Supplemental Schedules Required by ERISA***

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules listed on pages 17 and 18 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

***Supplemental Schedules Not Required by ERISA***

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. We previously expressed unmodified opinions on the 2020 through 2024 financial statements. The supplemental schedules presented on pages 19 to 23 are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements.

The supplemental schedules presented on pages 19 to 23 have been subjected to the auditing procedures applied in the audits of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.

***Forvis Mazars, LLP***

**Indianapolis, Indiana  
April 23, 2025**

**Federal Employer Identification Number: 44-0160260**

**Indiana State Council of Roofers  
Health and Welfare Fund  
Statements of Net Assets Available for Benefits  
October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>ASSETS</b>		
<b>Investments, At Fair Value</b>		
Money market funds	\$ 52,158,864	\$ 37,177,114
Mutual funds	54,258,474	41,154,782
Trust fund	4,973,926	4,631,730
Real estate investment trust	12,782,976	16,795,573
Fixed income fund	89,274,672	81,687,499
Infrastructure fund	12,993,826	12,053,264
Limited partnership	12,322,852	11,639,217
	<u>238,765,590</u>	<u>205,139,179</u>
<b>Noninterest-Bearing Cash</b>	<u>211,005</u>	<u>-</u>
<b>Receivables</b>		
Employers' contributions	9,420,389	8,889,526
Accrued interest and dividends	105,009	294,902
Reinsurance reimbursement	-	877,290
Prescription rebates	628,357	658,895
Subrogation	160,083	340,548
	<u>10,313,838</u>	<u>11,061,161</u>
<b>Prepaid Expenses</b>	<u>282,100</u>	<u>13,878</u>
Total assets	<u>249,572,533</u>	<u>216,214,218</u>
<b>LIABILITIES</b>		
Outstanding checks in excess of bank balance	-	74,451
Other accrued expenses	1,955,185	1,446,185
Total liabilities	<u>1,955,185</u>	<u>1,520,636</u>
<b>Net Assets Available for Benefits</b>	<u>\$ 247,617,348</u>	<u>\$ 214,693,582</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Statements of Changes in Net Assets Available for Benefits  
Years Ended October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>Investment Income</b>		
Net appreciation in fair value of investments	\$ 18,945,867	\$ 3,285,340
Interest and dividends	4,748,622	3,460,985
	<u>23,694,489</u>	<u>6,746,325</u>
Less: investment expense	(774,389)	(896,743)
Net investment income	<u>22,920,100</u>	<u>5,849,582</u>
<b>Contributions</b>		
Employers	80,631,713	75,921,592
Participants	5,752,677	5,732,418
	<u>86,384,390</u>	<u>81,654,010</u>
<b>Reinsurance Reimbursements and Subsidies</b>	(694,899)	1,292,255
Total additions	<u>108,609,591</u>	<u>88,795,847</u>
<b>Deductions</b>		
Claims paid		
Health care	65,014,594	55,217,037
Disability and death	1,830,895	1,306,127
	<u>66,845,489</u>	<u>56,523,164</u>
Reinsurance premiums	1,959,715	2,260,280
Administrative expenses	3,718,659	3,390,868
Cost containment fees	3,161,962	3,093,307
Total deductions	<u>75,685,825</u>	<u>65,267,619</u>
<b>Net Increase</b>	32,923,766	23,528,228
<b>Net Assets Available for Benefits, Beginning of Year</b>	<u>214,693,582</u>	<u>191,165,354</u>
<b>Net Assets Available for Benefits, End of Year</b>	<u>\$ 247,617,348</u>	<u>\$ 214,693,582</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Statements of Plan's Benefit Obligations  
October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>Amounts Currently Payable to or for Participants, Beneficiaries and Dependents</b>		
Health claims payable	\$ 3,900,000	\$ 1,673,536
<b>Other Obligations for Current Benefit Coverage, at Present Value of Estimated Amounts</b>		
Claims incurred but not reported	11,307,000	11,241,464
Accumulated eligibility credits	79,584,000	62,716,000
	<u>90,891,000</u>	<u>73,957,464</u>
<b>Total Obligation Other Than Postretirement Benefit Obligations</b>	<u>94,791,000</u>	<u>75,631,000</u>
<b>Postretirement Benefit Obligations</b>		
Current retirees, beneficiaries and dependents	85,395,383	70,485,452
Other participants fully eligible for benefits	75,161,395	55,771,744
Other participants not yet fully eligible for benefits	94,488,434	67,865,127
	<u>255,045,212</u>	<u>194,122,323</u>
<b>Plan's Total Benefit Obligations</b>	<u>\$ 349,836,212</u>	<u>\$ 269,753,323</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Statements of Changes in Plan's Benefit Obligations  
Years Ended October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>Amounts Currently Payable to or for Participants, Beneficiaries and Dependents</b>		
Beginning of year	\$ 1,673,536	\$ 804,891
Claims reported and approved for payment	69,071,953	57,391,809
Claims paid	<u>(66,845,489)</u>	<u>(56,523,164)</u>
End of year	<u>3,900,000</u>	<u>1,673,536</u>
<b>Other Obligations for Current Benefit Coverage, at Present Value of Estimated Amounts</b>		
Beginning of year	73,957,464	82,456,510
Net change during year		
Claims incurred but not reported	65,536	(488,046)
Accumulated eligibility credits	<u>16,868,000</u>	<u>(8,011,000)</u>
End of year	<u>90,891,000</u>	<u>73,957,464</u>
<b>Total Obligation Other Than Postretirement Benefit Obligations</b>	<u>94,791,000</u>	<u>75,631,000</u>
<b>Postretirement Benefit Obligations</b>		
Beginning of year	194,122,323	168,756,644
Increase (decrease) during the year attributable to		
Benefits earned and other changes	9,590,830	8,334,041
Actuarial loss	7,485,391	5,357,202
Estimated net benefits paid	(7,537,380)	(7,221,441)
Actuarial assumption changes	39,902,281	(2,443,148)
Plan amendments	(650,878)	11,635,518
Increase for interest due to the decrease in the discount period	<u>12,132,645</u>	<u>9,703,507</u>
End of year	<u>255,045,212</u>	<u>194,122,323</u>
<b>Plan's Total Benefit Obligations, End of Year</b>	<u>\$ 349,836,212</u>	<u>\$ 269,753,323</u>

## **Note 1. Description of the Plan**

The following description of the Indiana State Council of Roofers Health and Welfare Fund (Plan) provides only general information. Participants should refer to the Plan Document and *Summary Plan Description* for a more complete description of the Plan's provisions, which are available from the Plan Administrator.

### ***General***

The Plan is a multi-employer defined-benefit trust established in 1968 pursuant to an Agreement and Declaration of Trust between certain local unions located throughout several states. The purpose of this Plan is to provide health and welfare benefits to eligible employees and, where applicable, to their dependents working under collective bargaining agreements and retirees. Non-bargaining participation is allowed under specific provisions of the Plan. The Plan's affairs are administered by a Board of Trustees consisting of representatives from the local unions and employers. The Plan is subject to the provisions of the *Employee Retirement Income Security Act of 1974* (ERISA), as amended. Stewart C. Miller & Co., Inc. serves as the Plan Administrator and third-party claims processor.

### ***Eligibility***

A bargaining employee shall become eligible for basic health and welfare benefits on the first day of the second succeeding calendar month in which the bargaining employee has been credited with \$1,500 of contributions paid by a contributing employer. In addition, non-bargaining employees become eligible for basic health and welfare benefits on the first day of the second calendar month following the month in which the employer contributions are made on the non-bargaining employee's behalf. Initial eligibility cannot be established through self-contributions.

### ***Payment of Benefits***

Benefits paid by the Plan are provided on a self-funded basis. The Plan provides health and welfare benefits including hospital, surgical, prescription drug, dental, vision, major-medical, life and accidental death and dismemberment, and disability to eligible participants, as specified by the Plan, and their covered dependents and beneficiaries. Benefits are paid on behalf of eligible participants after they have satisfactorily complied with the claims procedures specified in the Plan. Claim payments are recorded when paid by the third-party claims processor. Amounts due to claims processors that have yet to be reimbursed by the Plan are recorded as other accrued expenses in the accompanying statements of net assets available for benefits.

The Plan provides health benefits to participants during periods of unemployment, provided they have accumulated in the current year or in prior years credit amounts (expressed in hours) in excess of the hours required for current coverage. Accumulated eligibility credits may be carried forward as defined in the Plan.

The Plan has a reinsurance policy in effect to limit the Plan's exposure on specific large claims. Effective March 1, 2023, under the terms of this reinsurance agreement, claims in excess of \$500,000 per participant shall be reimbursed to the Plan once the deductible is satisfied. Prior to March 1, 2023, the deductible amount was \$300,000 per participant. The Plan does not have aggregate coverage.

During 2024, the reinsurance provider determined that recorded reinsurance reimbursements of \$694,899 during the 2023 Plan year were for ineligible claims. The elimination of that related receivable was reflected as negative reinsurance reimbursements during 2024.

The Plan Administrator processes health, disability and death claims of active and retired participants, covered dependents and beneficiaries, but the responsibility for payments to participants and providers is retained by the Plan.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

---

***Contributions***

Employers make contributions to the Plan as specified in the various collective bargaining agreements. Contributions are also received from retired employees and from other individuals who may continue eligibility through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

***Plan Termination***

The Trustees anticipate that the Plan will continue indefinitely, but the Plan may be terminated at any time by an instrument in writing, executed by all employers, unions, and trustees who are part of the Plan. In the event of termination, wholly or partially, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

**Note 2. Summary of Significant Accounting Policies**

***Basis of Accounting***

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

***Use of Estimates***

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, incurred but not reported claims, eligibility credits, claims payable and disclosures of contingent assets and liabilities. Actual results could differ from those estimates.

***Investment Valuation and Income Recognition***

The Plan's investments are stated at fair value. Securities traded on a national securities exchange are valued at the last reported sales price on the last business day of the Plan year. Investments traded in the over-the-counter market and listed securities for which no sale was reported on that date are valued at the average of the last reported bid and asked prices.

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

***Postretirement Benefits***

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to contributing employers to October 31, 2024. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

---

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

For 2024 measurement purposes, a 7.90 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 2025; the rate was assumed to decrease gradually to 4.00 percent in 2040 and to remain at that level thereafter.

For 2023 measurement purposes, a 7.2 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 2024; the rate was assumed to decrease gradually to 4.0 percent in 2039 and to remain at that level thereafter.

The following were other significant assumptions used in the valuations as of October 31, 2024 and 2023:

Weighted-average discount rate	For 2024: 5.25% For 2023: 6.25%
Average retirement age	For 2024 and 2023: Ranging from 55 to 67+
Mortality	For 2024: 105% for males and 110% for females of the PRI-2012 Blue Collar Mortality Tables for employees and healthy annuitants projected forward using the MP-2021 projection scale For 2023: 105% for males and 110% for females of the PRI-2012 Blue Collar Mortality Tables for employees and healthy annuitants projected forward using the MP-2021 projection scale

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

***Other Plan Benefits***

Plan obligations for accumulated eligibility of participants and for future disability payments to members considered permanently disabled are estimated by the Plan's actuary in accordance with accepted actuarial principles. Such estimated amounts are reported in the accompanying statements of Plan's benefit obligations at present value, based on a 5.25 percent and 6.25 percent discount rate at October 31, 2024 and 2023, respectively. Health claims incurred by retired participants but not reported at year end are included in the postretirement benefit obligation.

Plan obligations for health claims incurred but not reported are estimated based upon historic claims experience and actual claims reported subsequent to the Plan year end. Additional accruals are included for the estimated ultimate cost of future claims only if such claims are covered as of the Plan's fiscal year end, and the Plan is obligated to pay for the care regardless of continued participation in the Plan.

***Administrative Expenses***

Administrative expenses are paid by the Plan.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

**Note 3. Disclosures About Fair Value of Plan Assets**

Fair value is the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

- Level 1** Quoted prices in active markets for identical assets
- Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets
- Level 3** Unobservable inputs supported by little or no market activity and are significant to the fair value of the assets

**Recurring Measurements**

The following tables present the fair value measurements of assets recognized in the accompanying statements of net assets available for benefits measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at October 31, 2024 and 2023:

	<b>Fair Value Measurements Using</b>			
	<b>Fair Value</b>	<b>Quoted Prices in Active Markets for Identical Assets (Level 1)</b>	<b>Significant Other Observable Inputs (Level 2)</b>	<b>Significant Unobservable Inputs (Level 3)</b>
<b>October 31, 2024</b>				
Investments in the fair value hierarchy				
Money market fund	\$ 52,158,864	\$ 52,158,864	\$ -	\$ -
Mutual funds	54,258,474	54,258,474	-	-
	<u>106,417,338</u>	<u>\$ 106,417,338</u>	<u>\$ -</u>	<u>\$ -</u>
Investments measured at net asset value (A)				
Trust fund	4,973,926			
Real estate investment trust	12,782,976			
Fixed income fund	89,274,672			
Infrastructure fund	12,993,826			
Limited partnership	12,322,852			
Total investments measured at net asset value	<u>132,348,252</u>			
Total investments at fair value	<u>\$ 238,765,590</u>			

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

	<b>Fair Value Measurements Using</b>			
	<b>Fair Value</b>	<b>Quoted Prices in Active Markets for Identical Assets (Level 1)</b>	<b>Significant Other Observable Inputs (Level 2)</b>	<b>Significant Unobservable Inputs (Level 3)</b>
<b>October 31, 2023</b>				
Investments in the fair value hierarchy				
Money market fund	\$ 37,177,114	\$ 37,177,114	\$ -	\$ -
Mutual funds	41,154,782	41,154,782	-	-
Total investments in the fair value hierarchy	<u>78,331,896</u>	<u>\$ 78,331,896</u>	<u>\$ -</u>	<u>\$ -</u>
Investments measured at net asset value (A)				
Trust fund	4,631,730			
Real estate investment trust	16,795,573			
Fixed income fund	81,687,499			
Infrastructure fund	12,053,264			
Limited partnership	11,639,217			
Total investments measured at net asset value	<u>126,807,283</u>			
Total investments at fair value	<u>\$ 205,139,179</u>			

(A) In accordance with Subtopic 820-10, certain investments that were measured at net asset value per share have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the line item presented in the statements of net assets available for benefits.

Following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the accompanying statements of net assets available for benefits, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the year ended October 31, 2024. The Plan had no liabilities measured at fair value on a recurring basis. In addition, the Plan had no assets or liabilities measured at fair value on a nonrecurring basis.

**Investments**

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections and cash flows. Such securities are classified in Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

***Investments Measured Using the Net Asset Value per Share Practical Expedient***

The following table summarizes investments for which fair value is measured using the net asset value per share practical expedient as of October 31, 2024 and 2023:

	<u>Fair Value</u>	<u>Unfunded Commitments</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
<b>October 31, 2024</b>				
Trust fund (B)	\$ 4,973,926	\$ -	Monthly	15 days
Real estate investment trust (C)	12,782,976	-	Quarterly	30 days
Fixed income fund (D)	89,274,672	-	Monthly	3 days
Infrastructure fund (E)	12,993,826	-	*Monthly	*45 days
Limited partnership (F)	12,322,852	-	Quarterly	90 days
<b>October 31, 2023</b>				
Trust fund (B)	\$ 4,631,730	\$ -	Monthly	15 days
Real estate investment trust (C)	16,795,573	-	Quarterly	30 days
Fixed income fund (D)	81,687,499	-	Monthly	3 days
Infrastructure fund (E)	12,053,264	-	*Monthly	*45 days
Limited partnership (F)	11,639,217	-	Quarterly	90 days

\* For the infrastructure fund, the redemption frequency and redemption notice period are first subject to a four year lock-up period from the date of initial acceptance, which commenced in November 2020, and ends in November 2024.

(B) The strategy for this investment for generating competitive risk-adjusted fixed-income returns is to construct and manage a portfolio with superior credit quality, higher yield and similar interest rate risk relative to the Bloomberg Barclays US Aggregate Bond Index (benchmark). The investment focuses on and over-weights high quality multi-family mortgage-backed securities that are structured to provide prepayment protection. These securities substitute for the benchmark's allocation to corporate debt and some U.S. treasury and government-sponsored enterprise debt securities.

(C) The strategy for this investment is to achieve a return premium through the application of research findings along with active asset management consisting of stabilized, income-producing, equity real estate diversified by property type and geography. The investment has both relative and real return objectives over the long-term: its relative performance objective is to exceed the NCREIF Fund Index-Open-End Diversified Core Equity, and its return objective is to achieve at least a 5 percent real rate of return before advisory fees.

(D) The strategy for this investment is to achieve a consistent total rate of return through a diversified portfolio of fixed income securities consisting primarily of U.S. government, corporate, and mortgage-backed securities. The long-term objective is to outperform the BloombergBarclays Intermediate Government Credit Index over a full market cycle.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

---

- (E) The strategy for this investment is to invest on a buy-and-hold basis in a diverse portfolio of quality infrastructure businesses in the United States and Canada in order to achieve attractive risk adjusted returns with significant annual cash yield and relatively low volatility. The fund's target market includes all essential, core infrastructure businesses that provide essential services to communities, governments, and businesses, with investments that may be made in the utility, transportation, social, and specialist sectors.
- (F) The strategy for this investment is to acquire and maintain a diversified portfolio of global infrastructure investments (with strong market positions, predictable regulatory environments, high barriers to entry, limited demand elasticity and long lives) that realize a 10% annual return over the long term (10+ years), which will range between 8%-12% per annum depending on the stage of the market cycle.

#### **Note 4. Benefit Obligations**

The Plan's deficiency of net assets over benefit obligations at October 31, 2024 and 2023 relates primarily to the postretirement benefit obligation, the funding of which is not covered by the current contribution rate. It is expected that the deficiency will be funded through future employer and self-contributions.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported as postretirement benefit obligations in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase this obligation as of October 31, 2024 and 2023 by \$37,177,901 and \$24,880,834, respectively.

#### **Note 5. Related Party and Party-in-Interest Transactions**

Party-in-interest transactions include those with fiduciaries or employees of the Plan, any person who provides services to the Plan, an employer whose employees are covered by the Plan, an employee organization whose members are covered by the Plan, a person who owns 50 percent or more of such an employer or employee association, or relatives of such persons.

The Plan invests in various securities of their investment managers. Fees for investment management services paid by the Plan to these investment managers were \$718,183 and \$853,548 for 2024 and 2023, respectively, which are included in investment expense on the statements of changes in net assets available for benefits.

The Plan Administrator, Stewart C. Miller & Co., Inc., provides certain administrative services to the Plan. Fees for administrative services paid by the Plan were \$2,656,644 and \$2,505,228 for 2024 and 2023, respectively.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

Cost containment fees paid to various service providers and preferred provider organizations, including Anthem, Hines & Associates, and SavRx for 2024 and 2023 are as follows:

	<u>2024</u>	<u>2023</u>
Anthem	\$ 2,669,473	\$ 2,609,817
Hines & Associates	488,124	477,986
SavRx	<u>4,365</u>	<u>5,504</u>
	<u>\$ 3,161,962</u>	<u>\$ 3,093,307</u>

The Plan has various other service providers, which are parties-in-interest under ERISA. Fees paid by the Plan to these service providers in 2024 and 2023 are included in the administrative expenses.

**Note 6. Tax Status**

The Plan, as established through a trust pursuant to Section 501(c)(9) of the Internal Revenue Code, previously obtained its latest determination letter on December 10, 1971, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the determination letter. However, the Plan Administrator believes that the Plan, as established through the trust, is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code, and that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

**Note 7. Risks and Uncertainties**

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

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

**Note 8. General Litigation**

The Plan is subject to claims and lawsuits that arise primarily in the ordinary course of operations. It is the opinion of management that the disposition or ultimate resolution of such claims and lawsuits will not have a material adverse effect on the financial position or the ability for the Plan to pay claims.

**Indiana State Council of Roofers  
Health and Welfare Fund  
Notes to Financial Statements  
October 31, 2024 and 2023**

---

**Note 9. Subsequent Events**

Subsequent events have been evaluated through April 23, 2025, which is the date the financial statements were available to be issued.

## **Supplemental Schedules**

**Indiana State Council of Roofers  
Health and Welfare Fund  
Employer Identification Number: 23-7067814 Plan Number: 501  
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)  
October 31, 2024**

Identity of Issuer	Description of Investment Including Maturity Date, Rate of Interest, Par or Maturity Value	Cost	Current Value
<b>Fixed Income Fund</b>			
NIS Intermediate Fixed Income Fund	4,053.599 units	\$ 66,076,137	\$ 89,274,672
<b>Mutual Funds</b>			
Eaton Vance Floating Rate Fund I	1,176,767.878 shares	10,379,732	9,861,315
Vanguard Total Stock Market Index Fund Admiral	324,493.193 shares	22,502,938	44,397,159
		<u>32,882,670</u>	<u>54,258,474</u>
<b>Limited Partnership</b>			
IFM Global Infrastructure (US), L.P. Class A Interests	0.08%	10,000,000	12,322,852
<b>Trust Fund</b>			
AFL-CIO Housing Investment Trust Fund	5,134.540 units	5,813,777	4,973,926
<b>Real Estate Investment Trust</b>			
Barings Core Property Fund	122,214.470 units	13,452,864	12,782,976
<b>Infrastructure Fund</b>			
Ullico Infrastructure Tax-Exempt Fund	44,699.173 units	9,706,040	12,993,826
<b>Money Market Fund</b>			
Goldman Sachs Financial Square Government Fund	2,768,864.000 shares	2,768,864	2,768,864
Morgan Stanley Government Investor Money Market Mutual Fund	49,390,000.000 shares	49,390,000	49,390,000
		<u>52,158,864</u>	<u>52,158,864</u>
Totals		<u>\$ 190,090,352</u>	<u>\$ 238,765,590</u>

\*Party-in-interest to the Plan

**Indiana State Council of Roofers**  
**Health and Welfare Fund**  
**Employer Identification Number: 23-7067814 Plan Number: 501**  
**Schedule H, Line 4j - Schedule of Reportable Transactions**  
**Year Ended October 31, 2024**

(a) Identity of Party Involved	(b) Description of Assets	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain (Loss)
Issuer	Morgan Stanley Government Investor Money Market Mutual Fund					
	Purchases	\$ 58,370,000		\$ 58,370,000	\$ 58,370,000	
	Sales		\$ 45,550,000	45,550,000	45,550,000	\$ -

**Indiana State Council of Roofers**  
**Health and Welfare Fund**  
**Schedule of Realized Gains (Losses) on Securities Sold**  
**Year Ended October 31, 2024**

<u>Type of Security</u>	<u>Sales</u>	<u>Cost</u>	<u>Realized Gain (Loss)</u>
<b>Real Estate Investment Trust</b>			
Barings Core Property Fund	\$ 2,119,602	\$ 2,211,758	\$ (92,156)
<b>Infrastructure Fund</b>			
Ullico Infrastructure Tax-Exempt Fund	<u>186,550</u>	<u>174,457</u>	<u>12,093</u>
Total	<u>\$ 2,306,152</u>	<u>\$ 2,386,215</u>	<u>\$ (80,063)</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Financial Highlights  
As of and for the Years Ended October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
Total assets	\$ 249,572,533	\$ 216,214,218
Total additions	\$ 108,609,591	\$ 88,795,847
Employers' and participants' contributions	\$ 86,384,390	\$ 81,654,010
Claims paid	\$ 66,845,489	\$ 56,523,164
Number of eligible participants covered at year end	7,164	6,923
Cost of administration:		
Amount	\$ 3,718,659	\$ 3,390,868
Percent to total additions	3.42%	3.82%
Net increase in net assets available for benefits	\$ 32,923,766	\$ 23,528,228

**Indiana State Council of Roofers  
Health and Welfare Fund  
Administrative Expenses  
Years Ended October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
Administrative expenses - paid to third party	\$ 2,656,644	\$ 2,505,228
Audit and tax fees	77,005	73,600
Accounting and payroll audit fees	81,795	122,576
Legal fees - Plan counsel and collection	257,246	174,050
Actuary expense	68,850	74,336
Printing and postage	373,363	290,057
Document scanning fees	35,832	19,427
Fiduciary insurance expense	23,730	18,319
Trustee meeting expense	64,408	68,071
Miscellaneous expense	<u>79,786</u>	<u>45,204</u>
Total administrative expenses	<u>\$ 3,718,659</u>	<u>\$ 3,390,868</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Claims Paid  
Years Ended October 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
Hospital Services		
Inpatient	\$ 15,747,090	\$ 12,906,323
Outpatient	27,575,879	22,341,341
Surgery	2,297,477	2,205,633
Physician services	2,272,038	2,276,409
X-Ray and laboratory	214,481	219,376
Prescription drug	4,262,434	3,675,660
Ambulance	526,128	354,160
Anesthesia	760,198	764,114
Medical supplies	630,363	624,331
Chiropractic	259,305	299,287
Dental	4,515,937	4,062,267
Vision	835,534	732,985
Loss of time	681,895	325,127
Other medical	3,105,125	2,646,115
Skilled nursing facility	62,783	113,940
Death benefit	1,149,000	981,000
Convalescent	29,834	226,002
COVID-19 testing	8,552	201,156
Flex benefits	1,884,538	1,856,149
	<u>66,818,591</u>	<u>56,811,375</u>
Total claims paid		
	<u>26,898</u>	<u>(288,211)</u>
Less subrogation settlements and adjustments		
Net claims paid	<u>\$ 66,845,489</u>	<u>\$ 56,523,164</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Five Year Summary of Operations  
Years Ended October 31, 2024, 2023, 2022, 2021, and 2020**

	<u>2024</u>	<u>2023</u>	<u>2022</u>	<u>2021</u>	<u>2020</u>
<b>Additions:</b>					
Employers' contributions	\$ 80,631,713	\$ 75,921,592	\$ 71,486,029	\$ 66,553,369	\$ 66,354,846
Participants' contributions	5,752,677	5,732,418	5,828,295	5,591,304	5,426,695
Investment income (loss) - net	22,920,100	5,849,582	(12,424,933)	17,923,265	8,046,019
Reinsurance reimbursements and subsidies	(694,899)	1,292,255	596,355	2,312,900	2,206,875
Total additions	<u>108,609,591</u>	<u>88,795,847</u>	<u>65,485,746</u>	<u>92,380,838</u>	<u>82,034,435</u>
<b>Deductions</b>					
Cost of benefits					
Claims paid	66,845,489	56,523,164	62,736,667	64,485,798	61,727,615
Reinsurance premiums	1,959,715	2,260,280	2,845,456	2,535,892	2,410,472
Cost containment fees	3,161,962	3,093,307	2,726,873	2,862,777	2,865,599
Total cost of benefits	<u>71,967,166</u>	<u>61,876,751</u>	<u>68,308,996</u>	<u>69,884,467</u>	<u>67,003,686</u>
Administrative expenses	3,718,659	3,390,868	3,296,700	3,261,839	3,045,016
Total deductions	<u>75,685,825</u>	<u>65,267,619</u>	<u>71,605,696</u>	<u>73,146,306</u>	<u>70,048,702</u>
<b>Net Increase (Decrease)</b>	32,923,766	23,528,228	(6,119,950)	19,234,532	11,985,733
<b>Net Assets, Beginning of Year</b>	<u>214,693,582</u>	<u>191,165,354</u>	<u>197,285,304</u>	<u>178,050,772</u>	<u>166,065,039</u>
<b>Net Assets, End of Year</b>	<u>\$ 247,617,348</u>	<u>\$ 214,693,582</u>	<u>\$ 191,165,354</u>	<u>\$ 197,285,304</u>	<u>\$ 178,050,772</u>

**Indiana State Council of Roofers  
Health and Welfare Fund  
Employer Identification Number: 23-7067814 Plan Number: 501  
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)  
October 31, 2024**

Identity of Issuer	Description of Investment Including Maturity Date, Rate of Interest, Par or Maturity Value	Cost	Current Value
<b>Fixed Income Fund</b>			
NIS Intermediate Fixed Income Fund	4,053.599 units	\$ 66,076,137	\$ 89,274,672
<b>Mutual Funds</b>			
Eaton Vance Floating Rate Fund I	1,176,767.878 shares	10,379,732	9,861,315
Vanguard Total Stock Market Index Fund Admiral	324,493.193 shares	22,502,938	44,397,159
		<u>32,882,670</u>	<u>54,258,474</u>
<b>Limited Partnership</b>			
IFM Global Infrastructure (US), L.P. Class A Interests	0.08%	10,000,000	12,322,852
<b>Trust Fund</b>			
AFL-CIO Housing Investment Trust Fund	5,134.540 units	5,813,777	4,973,926
<b>Real Estate Investment Trust</b>			
Barings Core Property Fund	122,214.470 units	13,452,864	12,782,976
<b>Infrastructure Fund</b>			
Ullico Infrastructure Tax-Exempt Fund	44,699.173 units	9,706,040	12,993,826
<b>Money Market Fund</b>			
Goldman Sachs Financial Square Government Fund	2,768,864.000 shares	2,768,864	2,768,864
Morgan Stanley Government Investor Money Market Mutual Fund	49,390,000.000 shares	49,390,000	49,390,000
		<u>52,158,864</u>	<u>52,158,864</u>
Totals		<u>\$ 190,090,352</u>	<u>\$ 238,765,590</u>

\*Party-in-interest to the Plan

**Indiana State Council of Roofers**  
**Health and Welfare Fund**  
**Employer Identification Number: 23-7067814 Plan Number: 501**  
**Schedule H, Line 4j - Schedule of Reportable Transactions**  
**Year Ended October 31, 2024**

(a) Identity of Party Involved	(b) Description of Assets	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain (Loss)
Issuer	Morgan Stanley Government Investor Money Market Mutual Fund					
	Purchases	\$ 58,370,000		\$ 58,370,000	\$ 58,370,000	
	Sales		\$ 45,550,000	45,550,000	45,550,000	\$ -