

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</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;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; 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>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 09/01/2023 and ending 08/31/2024

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>1a Name of plan <u>UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL NO.</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>UNITED FOOD AND COMMERCIAL WORKERS UNION</u></p> <p><u>300 WEIDMAN ROAD, SUITE A</u> <u>BALLWIN, MO 63011</u></p>	<p>1c Effective date of plan <u>09/01/1953</u></p> <p>2b Employer Identification Number (EIN) <u>23-7401847</u></p> <p>2c Plan Sponsor's telephone number <u>314-835-2700</u></p> <p>2d 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.

SIGN HERE	Filed with authorized/valid electronic signature.	06/13/2025	DAVID COOK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	5906
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	5724
	6a(2)	5385
	6b	118
	6c	
	6d	5503
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	56

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F 4H

9a Plan funding arrangement (check all that apply)	9b 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)

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

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

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) 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 **09/01/2023** and ending **08/31/2024**

A Name of plan UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL NO.	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 UNITED FOOD AND COMMERCIAL WORKERS UNION	D Employer Identification Number (EIN) 23-7401847

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

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0165030	5597	04/01/2023	03/31/2024

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

(a) Total amount of commissions paid 0	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(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.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		

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

a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	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) ▶ **ADD**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	263978
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection.
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For calendar plan year 2023 or fiscal plan year beginning **09/01/2023** and ending **08/31/2024**

A Name of plan UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL NO.	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 UNITED FOOD AND COMMERCIAL WORKERS UNION	D Employer Identification Number (EIN) 23-7401847	

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

THE VANGAURD GROUP, INC	PO BOX 2600 VALLEY FORGE, PA 19482
23-1945930	

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

PIMCO TOTAL RETURN FUND	
33-0629048	

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

BAIRD ADVISORS	777 E WISCONSIN AVE MILWAUKEE, WI 53202
39-6037917	

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

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

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

HEALTHY ALLIANCE LIFE INSURANCE COM

86-0257201

(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	2210819	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)

EXPRESS SCRIPTS

ON EXPRESS WAY
ST LOUIS, MO 63121

45-2884094

(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	NONE	601442	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)

BRIDGEWAY BENEFIT TECHNOLOGIES

3700 KOPPERS ST SUITE 400
BALTIMORE, MD 21227

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	236567	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 SEGAL COMPANY

101 N. WACKER DRIVE
CHICAGO, IL 60606

13-1975125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	210779	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)

DELTA DENTAL OF MISSOURI

43-0908349

(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	NONE	168921	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)

BRANDIE PENROD

23-7401847

(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?
30	NONE	107964	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)

REINHART, BORNER, VAN DEUREN, S.C.

1000 NORTH WATER STREET, SUITE 1700
MILWAUKEE, WI 53202

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	72096	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)

H&H HEALTH ASSOC., INC

3660 S GEYER RD 100
ST LOUIS, MO 63127

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	72000	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)

MAKALAH L. BOYER

23-7401847

(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?
30	NONE	71443	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)

HOLLY C. ROLAND

23-7401847

(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?
30	NONE	69750	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)

ERICKA SMITH

23-7401847

(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?
	NONE	68503	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)

ANDERS MINKLER HUBER HELM LLP

43-0831507

(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?
	NONE	67860	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)

BLADE TECHNOLOGIES

(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?
	NONE	67550	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)

ADRIANNE BAUTISTA

23-7401847

(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?
	NONE	63158	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)

COURTNEY SAFRON

23-7401847

(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?
30	NONE	62424	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)

AMY WENDLING

23-7401847

(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?
30	NONE	60551	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)

LINDA DOUGLAS

23-7401847

(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?
30	NONE	60307	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)

AMBER DARAIS

23-7401847

(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?
30	NONE	58487	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)

MELISSA BUCK

23-7401847

(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?
30	NONE	58089	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)

BARBARA ANDREWS

23-7401847

(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?
30	NONE	57248	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)

MCI PRINTING, INC.

10017 OFFICE CENTER AVENUE
ST LOUIS, MO 63128

(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?
36	NONE	57079	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)

MELISSA BOYER

23-7401847

(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?
30	NONE	46920	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)

RAYNA STANGE

23-7401847

(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?
30	NONE	43198	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)

ABSOLUTE SOLUTIONS LLC

2863 95TH ST
NAPERVILLE, IL 60564

(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	NONE	33258	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)

DATAMATION

770 GRIFFIN WAY
WILLOWBROOK, IL 60527

(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?
36	NONE	31400	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)

WESTERHEIDE & CO

11430 GRAVOIS RD
ST LOUIS, MO 63126

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	28769	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)

BURR OAK CONSULTING LLC

2115 BARRETT STATION RD.
ST LOUIS, MO 63131

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	28743	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)

JESSICA ANDREWS

23-7401847

(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?
30	NONE	26909	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)

VSP VISION CARE

36-3560825

(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	NONE	25237	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)

POSITIVE LEADER CONSULTING LLC

26333 JEFFERSON SUITE 102
ST. CLAIR SHORES, MI 48081

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	16200	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)

HAMMOND & SHINNERS, PC

7730 CARONDELET
CLAYTON, MO 63105

43-1429257

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	15833	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)

MIDWEST HEALTH INITIATIVE

8888 LADUE RD 250
ST LOUIS, MO 63124

(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?
	NONE	11500	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)

CONTEXT 4 HEALTHCARE

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	7262	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)

SEGAL MARCO ADVISORS

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	NONE	5000	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.

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning 09/01/2023 and ending 08/31/2024	
A Name of plan UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL NO.	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 UNITED FOOD AND COMMERCIAL WORKERS UNION	D Employer Identification Number (EIN) 23-7401847

Part I	Asset and Liability Statement
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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
a Total noninterest-bearing cash	1a	1866766	3086115
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	4426018	5100369
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	5137083	3075247
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	21441485	16449663
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	889157	781925
f Total assets (add all amounts in lines 1a through 1e)	1f	33760509	28493319
Liabilities			
g Benefit claims payable	1g	9047200	7828000
h Operating payables	1h	44141	41348
i Acquisition indebtedness	1i		
j Other liabilities	1j	1739650	1271200
k Total liabilities (add all amounts in lines 1g through 1j)	1k	10830991	9140548
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	22929518	19352771

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	54205394	
(B) Participants	2a(1)(B)	2019332	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		56224726
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends:			
(A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	810870	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		810870
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1220008
c Other income	2c		208654
d Total income. Add all income amounts in column (b) and enter total	2d		58464258

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	58620199	
(2) To insurance carriers for the provision of benefits.....	2e(2)	270000	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		58890199
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)	891627	
(2) Contract administrator fees.....	2i(2)		
(3) Recordkeeping fees.....	2i(3)	23710	
(4) IQPA audit fees.....	2i(4)	104152	
(5) Investment advisory and investment management fees	2i(5)	5000	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	206279	
(8) Legal fees	2i(8)	407408	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	1512630	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		3150806
j Total expenses. Add all expense amounts in column (b) and enter total	2j		62041005

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-3576747
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **ANDERS MINKLER HUBER HELM LLP**

(2) EIN: **43-0831507**

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
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
e Was this plan covered by a fidelity bond?.....	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.).....	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

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

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

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

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

UNITED FOOD & COMMERCIAL WORKERS UNION LOCAL NO. 655, HEALTH & WELFARE FUND

**FINANCIAL STATEMENTS WITH SUPPLEMENTARY INFORMATION
AND ADDITIONAL INFORMATION
AND
INDEPENDENT AUDITORS' REPORT
YEARS ENDED AUGUST 31, 2024 AND 2023**

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Independent Auditors' Report

Board of Trustees
United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
St. Louis, Missouri

Opinion

We have audited the accompanying financial statements of United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund (the "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 benefit obligations as of August 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 financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Fund as of August 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in its 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 Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the 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 the Fund's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditors' Responsibilities for the Audit of the 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 auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is 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 the 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 the 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 Schedule of Assets (Held at End of Year) and Schedule of Reportable Transactions 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.

Report on Additional Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The additional Schedules of Administrative Expenses are presented for purposes of additional analysis and are not a required part of the 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 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 our opinion, the additional information is fairly stated in all material respects in relation to the financial statements as a whole.

Anders Minkler Huber & Helms LLP

June 11, 2025

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Statements of Net Assets Available for Benefits
August 31, 2024 and 2023

Assets	<u>2024</u>	<u>2023</u>
Investments, at Fair Value	\$ 16,449,663	\$ 21,441,485
Receivables		
Employer contributions	5,100,369	4,426,018
Due from broker	-	2,000,000
Litigation receivable	672,202	997,000
Claims refunds	335,546	-
Rebates receivable	2,067,499	2,140,083
Total Receivables	<u>8,175,616</u>	<u>9,563,101</u>
Furniture and Equipment, net	74,670	85,970
Cash - Noninterest Bearing	3,086,115	1,866,766
Operating Right-of-Use Assets	627,100	697,719
Financing Right-of-Use Assets	80,155	105,468
Total Assets	<u>28,493,319</u>	<u>33,760,509</u>
Liabilities		
Current Liabilities		
Current maturities of operating lease liabilities	71,261	73,239
Current maturities of financing lease liabilities	25,087	24,041
Accounts payable and accrued expenses	41,348	44,141
Deferred revenue	567,079	938,249
Total Current Liabilities	<u>704,775</u>	<u>1,079,670</u>
Long-term Operating Lease Liabilities	549,606	620,866
Long-Term Financing Lease Liabilities	58,167	83,255
Total Liabilities	<u>1,312,548</u>	<u>1,783,791</u>
Net Assets Available for Benefits	<u>\$ 27,180,771</u>	<u>\$ 31,976,718</u>

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Statements of Changes in Net Assets Available for Benefits
Years Ended August 31, 2024 and 2023

	2024	2023
Additions to Net Assets:		
Investment Income		
Net appreciation (depreciation) in fair value of investments	\$ 1,220,008	\$ (525,077)
Interest and dividends	810,870	967,737
Net Investment Income	2,030,878	442,660
Contribution Income		
Employer contributions	54,205,394	54,208,488
Participant contributions		
Normal	1,013,522	1,102,910
Spousal surcharge	1,005,810	1,036,320
Total Participant Contributions	2,019,332	2,139,230
Total Contribution Income	56,224,726	56,347,718
Litigation Settlement	-	997,000
Other Income	208,654	66,331
Total Additions	58,464,258	57,853,709
Deductions from Net Assets:		
Benefits Paid on Behalf of Participants:		
Medical	44,019,795	50,611,197
Disability	1,452,909	1,833,161
Life insurance premiums	270,001	380,170
Pharmacy, net	11,709,553	9,802,153
Dental	2,402,521	2,480,548
Vision	254,620	260,751
Total Benefits Paid	60,109,399	65,367,980
Benefit Administrative Fees		
Network provider/access fees	105,258	103,450
ACA fees	52,701	-
Total Benefit Administrative Fees	157,959	103,450
Administrative Expenses	2,992,847	2,793,737
Total Deductions	63,260,205	68,265,167
Net Decrease	(4,795,947)	(10,411,458)
Net Assets Available for Benefits, Beginning of Year	31,976,718	42,388,176
Net Assets Available for Benefits, End of Year	\$ 27,180,771	\$ 31,976,718

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Statements of Benefit Obligations
August 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Amounts Currently Payable to or for Participants, Beneficiaries and Dependents:		
Claims payable	\$ 1,565,600	\$ 7,237,800
Claims incurred but not reported	<u>6,262,400</u>	<u>1,809,400</u>
Total Amounts Currently Payable	<u>7,828,000</u>	<u>9,047,200</u>
Postemployment Benefit Obligations, at Estimated Amounts:		
Accumulated eligibility credits	<u>13,680,000</u>	<u>13,850,000</u>
Total Benefit Obligations Other Than Postretirement Benefit Obligations	<u>21,508,000</u>	<u>22,897,200</u>
Postretirement Benefit Obligations		
Current retirees, beneficiaries, and dependents	2,142,678	974,412
Other participants fully eligible for benefits	1,831,522	2,735,450
Other participants not yet fully eligible for benefits	<u>9,712,068</u>	<u>9,108,269</u>
Total Postretirement Benefit Obligations	<u>13,686,268</u>	<u>12,818,131</u>
Total Benefit Obligations, End of Year	<u>\$ 35,194,268</u>	<u>\$ 35,715,331</u>

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Statements of Changes in Benefit Obligations
Years Ended August 31, 2024 and 2023

	2024	2023
Amounts Currently Payable to or for Participants, Beneficiaries and Dependents:		
Balance at beginning of year	\$ 9,047,200	\$ 10,931,100
Claims and premiums incurred and approved for payment	58,890,199	63,484,080
Claims and insurance premiums paid	<u>(60,109,399)</u>	<u>(65,367,980)</u>
Balance at end of year	<u>7,828,000</u>	<u>9,047,200</u>
Postemployment Benefit Obligations, at Estimated Amounts:		
Balance at beginning of year	13,850,000	12,110,000
Net change during year	<u>(170,000)</u>	<u>1,740,000</u>
Balance at end of year	<u>13,680,000</u>	<u>13,850,000</u>
Total Obligations for Current Benefit Coverage	21,508,000	22,897,200
Postretirement Benefit Obligations, Net of Amounts Currently Payable		
Balance at beginning of year	12,818,131	13,919,997
Increase (decrease) during the year attributable to:		
Benefits earned net of benefits paid	(872,918)	(1,076,816)
Changes in actuarial assumptions	586,445	(25,050)
Actuarial experience loss	<u>1,154,610</u>	<u>-</u>
Balance at end of year	<u>13,686,268</u>	<u>12,818,131</u>
Total Benefit Obligations, End of Year	<u>\$ 35,194,268</u>	<u>\$ 35,715,331</u>

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

1. Description of the Fund

The following description of the United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund (the "Fund") provides only general information. Participants of the Fund should refer to the fund document and the summary plan description for a more complete description of the Fund's provisions.

General

The Fund is a multiemployer defined benefit health and welfare fund. The Fund was established and is maintained pursuant to a collective bargaining agreement ("CBA") between the United Food & Commercial Workers Union Local No. 655, Local No. 881, Local No. 534 and Local No. 700 (the "Unions") and various contractors (the "Employers") to provide medical, prescription drug, dental, vision, life, accidental death and dismemberment, and disability benefits to eligible participants and beneficiaries. The Fund is subject to the provisions of the Employer Retirement Income Security Act of 1974 ("ERISA"), as amended.

Administration of the Fund is the responsibility of the Board of Trustees (the "Trustees") and is governed by a joint board consisting of equal representation from the Employers and the Union.

Eligibility

Participants and their eligible dependents become eligible for benefits based on the average number of weekly hours worked each month for which an Employer contributes to the Fund on their behalf, after a 12-month waiting period, as defined in the summary plan description. Effective January 1, 2023, the 12-month waiting period was removed and replaced with a 60-day waiting period. Participants may be required to pay a share of the premium for benefit coverage, as determined by their Employers' CBA. Eligibility is measured each year in October for coverage in the following calendar year.

Generally, a participant will remain eligible as long as actively employed with an Employer. Participants may also continue to remain eligible for benefits through the use of accumulated eligibility credits for times of unemployment (less than full time) and upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

Retired employees are entitled to benefits if they are an eligible retired participant of the UFCW Local Union 655 Pension Plan and are receiving a standard, early retirement, or disability pension and were covered by the Fund immediately prior to the effective date of retirement.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

Contributions

Under the terms of the CBA, the Employers contribute monthly amounts to the Fund for each hour worked at a set rate per employee. Participant contributions are allowed to provide COBRA benefits and participants pay the full cost of such benefits. Retired participants are also required to make contributions for their benefits.

On October 15, 2019, the Trustees of the Fund approved a contribution credit (the "Holiday Credit") for Employers with employees that generate a low benefit utilization, measured in claim dollars incurred. Employers are eligible for the Holiday Credit if the claim dollars incurred by their employees are less than the Employer's contributions paid in for the calculation period. On an annual basis, the Fund employs a specialist to assist in determining the amount of the Employers' Holiday Credit. Effective for the year ended August 31, 2023, any employer that has the Holiday Credit benefit stated in their CBA is eligible to receive the credit, regardless of their employees low benefit utilization. The credits awarded reduce the required contributions from Employers in future periods. For the years ended August 31, 2024 and 2023, the total reduction in Employer contributions was approximately \$4,951,000 and \$4,705,000, respectively.

Benefits

The Fund provides for medical, prescription drug, dental, vision, life, accidental death and dismemberment, and disability benefits for covered employees and their families.

Dental claims are self-funded and administered by Anthem Dental. Effective January 1, 2023, the dental claims are administered by Delta Dental. Claims for medical benefits are processed and paid for by the Fund administrator. Claims for prescription drug and vision benefits are administered by Express Scripts and Vision Service Plan, respectively, on a self-funded basis. The claims for these benefits are processed by the Fund's third-party claims processors under administrative services only ("ASO") arrangements. The claims processors pay claims directly to or on behalf of the participants. Despite the Fund's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Fund. The Fund uses a pharmacy benefit manager ("PBM"), which periodically makes refunds to the Fund based on the Fund's actual utilization pattern of specific drugs. Life insurance and accidental death and dismemberment benefits are provided under the terms of group insurance policies with MetLife.

2. Summary of Significant Accounting Policies

Basis of Accounting

The financial statements of the Fund have been prepared in accordance with the provisions of the Financial Accounting Standards Board ("FASB"), Accounting Standards Codification (the "FASB ASC"), which is the source of authoritative, non-governmental accounting principles generally accepted in the United States of America ("GAAP"). All references to authoritative accounting guidance contained in our disclosures are based on the general accounting topics within the FASB ASC.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect certain reported amounts of assets, liabilities, benefit obligations and changes therein, incurred but not reported, claims payable, accumulated eligibility credits, and disclosure of contingent assets and liabilities. Accordingly, actual results could differ from those estimates.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

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 fair value of investments includes the Fund's gains and losses on investments bought and sold as well as held during the year.

Fair Value Measurements

The Fund follows guidance issued by the FASB on fair value measurements, which establishes a framework for measuring fair value, clarifies the definition of fair value within that framework, and expands disclosures about the use of fair value measurements. This guidance applies whenever fair value is the applicable measurement. The three general valuation techniques used to measure fair value are the market approach, cost approach, and income approach.

Employer Contributions Receivable

Employer contributions receivable represent Employer contributions due to the Fund for hours worked by participants prior to the end of the Fund year. Employer contributions receivable are carried at reported amounts. The Employer contributions receivable balance has been fully collected subsequent to year-end. No allowance for credit losses is necessary as of August 31, 2024 and 2023.

Refunds and Rebates

Prescription refunds due from the Fund's PBM are recorded when earned. Refunds due at year-end are recorded as a receivable on the statements of net assets available for benefits, with the offset being netted against prescription claims paid. Pharmacy rebates totaling \$5,504,427 and \$6,091,691 for the years ended August 31, 2024 and 2023, respectively, have been netted against prescription claims paid in the accompanying statements of changes in net assets available for benefits.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

Furniture and Equipment

Furniture and equipment is stated at cost. Major additions and improvements are capitalized, while maintenance and repairs are expensed as incurred. When assets are sold or otherwise disposed of, the related cost and accumulated depreciation are removed from the accounts. Any gain or loss arising from such disposition is included as additions or deductions in the year of disposition.

Depreciation is computed using the straight-line method over the estimated useful lives of the assets.

The estimated lives for computing depreciation on furniture and equipment are:

<u>Classification</u>	<u>Years</u>
Furniture and equipment	3-10

Long-Lived Asset Impairment

The Fund evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset are less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value. Management does not believe any impairment exists as of August 31, 2024 or 2023.

Leases

The Fund leases certain equipment and a building. The Fund assesses whether an arrangement qualifies as a lease (conveys the right to control the use of an identified asset for a period of time in exchange for consideration) at inception and only reassesses its determination if the terms and conditions of the arrangement are modified. The Fund has recognized a liability representing the future lease payments and a right-of-use asset ("ROU") representing its right to use the underlying asset for the lease term. As most of the leases do not provide an implicit rate, the Fund elected to use the practical expedient to use the risk-free rate of return at the commencement date in determining the present value of lease payments. The Fund has elected to treat leases with a lease term of 12 months or less as short term leases and are not recorded on the statements of net assets available for benefits. Lease expense is recognized on a straight-line basis over the lease term for short term leases, and variable lease expenses are recognized in the period in which they are incurred. The Fund has elected not to separate lease components from nonlease components for the building when allocating consideration under the terms of the lease.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

Deferred Revenue

Deferred revenue consists of the Holiday Credits that have been awarded but have not been used by the Employer.

Payment of Benefits

Claim payments are recorded when submitted to the Fund by the third-party claims processor for reimbursement.

Fund Benefit Obligations

Claims paid by the claims processor prior to year-end or claim payments submitted to the Fund by the third-party claims processor that are not yet paid are recorded as claims currently payable in the accompanying statements of benefit obligations.

Fund benefit obligations for claims payable, claims incurred by active participants but not reported by active participants, and accumulated eligibility credits at year end are estimated by the Fund's consultant. The Fund's postemployment benefit obligation for accumulated eligibility credits is calculated based on the number of months of future eligibility earned under the terms of the Fund as of year end, multiplied by the Fund's estimated monthly benefit cost per individual. Such estimated amounts are reported in the accompanying statements of the Fund's benefit obligations at present value. Postretirement benefit obligations are determined in accordance with accepted actuarial principles. These amounts are paid by the Fund only if claims are submitted and approved for payment.

Administrative Expenses

The Fund permits the payment of Fund expenses from Fund assets.

Reclassifications

Certain amounts in the 2023 financial statements have been reclassified to conform to the current year presentation.

Subsequent Events

The Fund has evaluated subsequent events through June 11, 2025, the date on which the financial statements were available to be issued.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

3. Change in Accounting Principle

Effective September 1, 2023, the Fund adopted ASU 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, as amended. FASB ASC 326 replaces the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss ("CECL") methodology. CECL requires an estimate of future credit losses for the remaining estimated lives of financial assets based on relevant information about historical experience, current conditions, and reasonable and supportable financial forecasts that affect the collectibility of the reported amounts. The measurement of expected credit losses under CECL is applicable to financial assets measured at amortized cost. Such assets are presented at the net amount expected to be collected over their remaining contractual lives using an allowance for credit losses. The adoption of FASB ASC 326 resulted in no change in the allowance for credit losses.

4. Postretirement Benefit Obligations

The amount reported as postretirement benefit obligations represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Fund to employee service rendered to August 31. 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 with the participating Employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Fund's participating Employers and from existing Fund assets. 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 in the industry rendered to the valuation date. The obligation is net of anticipated self-payments.

The actuarial present value of the expected postretirement benefit obligation is determined by the Fund's 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.

The current medical trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the postretirement obligation as of August 31, 2024 and 2023, by \$995,577 and \$930,202, respectively.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

The following are significant assumptions used in the valuation at August 31, 2024 and 2023:

Actuarial cost method:	Projected unit credit
Discount rate:	2024: 4.75% 2023: 5.00%
Health cost inflation:	2024: 8.00% graded to 4.50% over 10 years 2023: 7.50% graded to 4.50% over 10 years
Dental cost inflation:	2024: 4.00% 2023: 4.00%
Mortality table:	2024: 110% of the RP-2006 Headcount-weighted Blue Collar Annuitant Mortality Table, projected generally using Scale MP-2019 from 2006 2023: 110% of the RP-2006 Headcount-weighted Blue Collar Annuitant Mortality Table, projected generally using Scale MP-2019 from 2006
Retirement rates:	2024 Ages 52-54, 1%; ages 55-56, 2%; ages 57-59, 5%; ages 60-61, 15%; age 62, 30%; ages 63-64, 20%; age 65, 30%; ages 66-70, 25%, age 71 and older, 100% 2023 Ages 52-54, 1%; ages 55-56, 2%; ages 57-59, 5%; ages 60-61, 15%; age 62 and older, 30%
Administrative expenses increase rate:	An administrative expense and network fees cost of \$821 per person increasing at 2.5% per year was added to projected incurred claim costs in developing the benefit obligations for 2024, \$602 per person increasing 2.5% per year for 2023.

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

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

5. Fair Value Measurements

The framework for measuring fair value establishes a fair value hierarchy which prioritizes the inputs to valuation techniques used to measure fair value into Levels 1, 2, and 3. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

- Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical instruments in active markets.

- Level 2 Inputs to the valuation methodology to include quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in inactive markets, inputs other than quoted prices that are observable for the instrument, or inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

The instruments' fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for investments measured at fair value.

Level 1 investments consist mutual funds. Mutual funds are recorded at the closing price recorded by the funds. These are open ended mutual funds and are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price. The mutual funds held by the Fund are deemed to be actively traded.

The fair value of investments is measured as of August 31, as follows:

	2024			
	Total	Fair Value Measurements		
	Level 1	Level 2	Level 3	
Mutual funds	\$ 16,449,663	\$ 16,449,663	\$ -	\$ -
Total assets in the fair value hierarchy	\$ 16,449,663	\$ 16,449,663	\$ -	\$ -

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

	2023			
	Total	Fair Value Measurements		
		Level 1	Level 2	Level 3
Mutual funds	\$ 21,441,485	\$ 21,441,485	\$ -	\$ -
Total assets in the fair value hierarchy	\$ 21,441,485	\$ 21,441,485	\$ -	\$ -

6. Property and Equipment

Property and equipment at August 31, is as follows:

	2024	2023
Furniture and Equipment	\$ 469,775	\$ 469,775
Less: Accumulated depreciation	(395,105)	(383,805)
	\$ 74,670	\$ 85,970

Depreciation expense for each of the years ended August 31, 2024 and 2023 totaled \$11,301 and \$14,099, respectively.

7. Leases

The Fund has operating and financing leases of buildings and for certain equipment. The following summarizes the weighted average remaining lease term and discount rate as of August 31, :

	2024	2023
Weighted Average Remaining Lease Term		
Operating leases	8.46 years	9.33 years
Finance leases	3.17 years	4.17 years
Weighted Average Discount Rate		
Operating leases	3.60 %	3.60 %
Finance leases	4.27 %	4.27 %

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

The maturities of lease liabilities as of August 31, are as follows:

<u>Years Ending August 31,</u>	<u>Operating</u>	<u>Finance</u>
2025	\$ 92,222	\$ 28,055
2026	92,222	28,055
2027	84,289	28,055
2028	76,547	4,676
2029	77,310	-
Thereafter	<u>296,772</u>	<u>-</u>
Total Lease Payments	719,362	88,841
Less: Interest	<u>(98,495)</u>	<u>(5,587)</u>
Present Value of Lease Liabilities	<u>\$ 620,867</u>	<u>\$ 83,254</u>

The components of lease expense for the years ended August 31, are as follows:

	<u>2024</u>	<u>2023</u>
Finance lease expenses:		
ROU asset amortization	\$ 25,312	\$ 21,094
Interest expense	4,015	4,114
Operating lease expense	94,095	41,377
Short-term lease expense	806	40,999
Total net lease expense	<u>\$ 124,228</u>	<u>\$ 107,584</u>

8. Retirement Plans

The Fund contributes to one multiemployer defined benefit pension plan under the terms of a collective-bargaining agreement that covers its union employees. The risk of participating in U.S. multiemployer pension plans is different from single-employer pension plans in the following aspects:

- Assets contributed to the multiemployer plan by one employer may be used to provide benefits of employment to other participating employers.
- If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.
- If the Fund stops participating in some of its multiemployer pension plans, it may be required to make payments to the plan for its proportionate share of the multiemployer plan's unfunded vested liabilities.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

The Fund’s participation in this plan for the years ended August 31, 2024 and 2023 is outlined in the following table. The Pension Protection Act (“PPA”) zone status column ranks the funded status of multiemployer pension plans depending upon a plan’s current and projected funding and is based on information the Fund received from the plan and is certified by the plan’s actuary. The most recent PPA zone status available for the years ended August 31, 2024 and 2023 is for the plan’s year-end at December 31, 2023 and 2022, respectively. Among other factors, a plan is in the red zone if it has a current funded percentage less than 65 percent, in the yellow zone if it has a current funded percentage between 65 - 80 percent, or projects a credit balance deficit within seven years, and a plan is in the green zone if it has a current funded percentage greater than 80 percent and does not have a projected credit balance deficit within seven years. Information with respect to the multiemployer defined benefit pension plan in which the Fund participates is as follows:

<u>Pension Fund</u>	<u>EIN/Pension Plan Number</u>	<u>2023</u>		<u>FIP/RP Status Pending/ Implemented</u>	<u>Entity Contributions</u>		<u>Surcharge Imposed</u>	<u>Expiration Date</u>
		<u>2024</u>	<u>2023</u>		<u>2024</u>	<u>2023</u>		
UFCW Local 655 Pension Plan	43-6058365 Plan No. 001	Green	Green	Yes	\$ 37,246	\$ 48,269	No	N/A

The Fund also established a defined contribution 401(k) retirement plan for the benefit of the nonunion administrative employees of the Fund. The contributions to this plan for the years ended August 31, 2024 and 2023, were funded entirely from employee wage deferrals.

The Fund also provides health and welfare benefits to these employees. Contributions to this Fund for the years ended August 31, 2024 and 2023, totaled \$154,716 and \$190,928, respectively.

9. Fund Amendments

In January 2024, the Fund was amended to provide that a participant who fails to provide documentation supporting their dependents during their open enrollment will drop down to employee-only coverage in the following calendar year.

Effective January 1, 2023, the Fund was amended to reduce the participation waiting period for a full-time employee from 12 months to 60 days.

Effective September 1, 2022, the Fund was amended to update and add various definitions.

10. Fund Termination

Although they have not expressed any intent to do so, the Trustees have the right under the Fund to terminate the Fund subject to the provisions of ERISA. In the event the Fund terminates, any assets remaining shall be used solely for purposes of providing benefits and defraying the reasonable cost of administering the Fund. No assets shall revert to the contributing Employers.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

11. Tax Status of Fund

The Internal Revenue Service has determined and informed the Trustees by a letter dated September 1974, that the Fund and related trust are designed in accordance with the applicable sections of the Internal Revenue Code ("IRC"). The Fund has been amended since receiving the determination letter. Management believes that the Fund is designed and is currently being operated in compliance with the applicable requirements of the IRC and therefore believes that the Fund is qualified and the related trust is tax-exempt.

In accordance with GAAP, management is required to evaluate tax positions taken by the Fund and recognize a tax liability if the Fund has taken an uncertain position that more likely than not would not be sustained upon examination by the applicable taxing authorities. Management has analyzed the tax positions taken by the Fund and has concluded that as of August 31, 2024 and 2023, there were no uncertain positions taken, or expected to be taken, that would require the recognition of a liability or disclosure in the financial statements. Management believes the Fund is no longer subject to income tax examinations prior to 2021. The Fund is also subject to routine audits by the Department of Labor generally for six years after the statutory due date of the annual information return. There are currently no audits in progress for any tax periods.

12. Risks and Uncertainties

Concentration of Credit Risk

Financial instruments that subject the Fund to concentrations of credit and market risk consist of cash, investments, and receivables. The Fund maintains its cash primarily with two financial institutions. Deposits at these financial institutions are insured by the Federal Deposit Insurance Corporation ("FDIC") up to \$250,000. At August 31, 2024, there were cash balances of \$2,495,462 in excess of FDIC limits at the financial institutions.

Investments

The Fund 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 those changes could materially affect the amounts reported in the statements of net assets available for benefits.

Contribution Receivables

The majority of receivables are from Employers in Missouri. The Fund generally does not require collateral, but in some cases can require a performance bond.

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Notes to Financial Statements
August 31, 2024 and 2023

Benefit Obligations

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions 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.

13. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at August 31, to Form 5500:

	2024	2023
Net assets available for benefits per the financial statements	\$ 27,180,771	\$ 31,976,718
Benefit obligations currently payable	(7,828,000)	(9,047,200)
Net assets available for benefits per the Form 5500	\$ 19,352,771	\$ 22,929,518

The following is a reconciliation of benefits paid per the financial statements for the year ended August 31, to Form 5500:

	2024
Benefits paid per the financial statements	\$ 60,109,399
Plus: claims payable current year	7,828,000
Less: claims payable prior year	(9,047,200)
Benefits paid per Form 5500	\$ 58,890,199

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
EIN: 23-7401847 Plan Number: 501
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
August 31, 2024

(a)	Identity of Issuer, Borrower, Lessor or Similar Party (b and c)	Cost (d)	Current Value (e)
MUTUAL FUNDS			
	Baird Core Plus Bond-Institutional Class	\$ 4,923,309	\$ 4,647,412
	JPMorgan Short Duration Bond Fund	5,344,371	5,320,828
	PIMCO Total Return Institutional Class	6,013,707	4,668,833
	Vanguard 500 Index Adm	<u>702,845</u>	<u>1,812,590</u>
	TOTAL MUTUAL FUNDS	<u>\$ 16,984,232</u>	<u>\$ 16,449,663</u>

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
EIN: 23-7401847 Plan Number: 501
Schedule H, Line 4j - Schedule of Reportable Transactions
Year Ended August 31, 2024

Identity of Party Involved (a)	Description of Asset (b)	Purchase Price (c)	Selling Price (d)	Cost of Asset (g)	Current Value of Asset on Transaction Date (h)	Net Gain (Loss) (i)
<u>Series of transactions involving securities of the same issue in excess of 5%:</u>						
Baird Core Plus Bond Instl Class	Baird Core Plus Bond Inst Class (3)	\$ -	\$ 2,500,030	\$ 2,681,341	\$ 2,500,030	\$ (181,311)

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
Schedules of Administrative Expenses
Years Ended August 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Administration fees - payroll	\$ 12,153	\$ 32,408
Administration fees - 401(k) plan	1,527	3,993
Administration fees - VPay	-	1,172
Accounting fees	23,710	9,838
Bank charges	35,752	31,672
Audit fees	44,150	30,000
Computer expenses	381,178	350,717
Consulting fees	206,279	126,833
Claims audit fees	28,743	26,895
Depreciation expense	11,301	14,099
Employee benefits	294,605	355,548
Investment consulting	5,000	10,000
Insurance	108,770	133,983
Legal fees	407,408	105,687
Meetings and conventions	61,334	44,585
Miscellaneous	5,994	10,259
Office salaries	891,627	926,969
Office supplies and expense	82,458	167,305
Payroll audit fees	31,259	27,687
Payroll taxes	74,598	86,206
Printing and postage	104,365	84,678
Rent	124,228	146,355
Telephone	<u>56,408</u>	<u>66,848</u>
 Total administrative expenses	 <u>\$ 2,992,847</u>	 <u>\$ 2,793,737</u>

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
EIN: 23-7401847 Plan Number: 501
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
August 31, 2024

(a)	Identity of Issuer, Borrower, Lessor or Similar Party (b and c)	Cost (d)	Current Value (e)
MUTUAL FUNDS			
	Baird Core Plus Bond-Institutional Class	\$ 4,923,309	\$ 4,647,412
	JPMorgan Short Duration Bond Fund	5,344,371	5,320,828
	PIMCO Total Return Institutional Class	6,013,707	4,668,833
	Vanguard 500 Index Adm	<u>702,845</u>	<u>1,812,590</u>
	TOTAL MUTUAL FUNDS	<u><u>\$ 16,984,232</u></u>	<u><u>\$ 16,449,663</u></u>

Form 5500 Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210 - 0110 1210 - 0089 <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2023</div> <hr/> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2023 or fiscal plan year beginning <u>09/01/2023</u> and ending <u>08/31/2024</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is:	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	<input type="checkbox"/>

Part II Basic Plan Information - enter all requested information	
1a Name of plan UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL NO.	1b Three-digit plan number (PN) ▶ 501 1c Effective date of plan 09/01/1953
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) UNITED FOOD AND COMMERCIAL WORKERS UNION 300 WEIDMAN ROAD, SUITE A BALLWIN MO 63011	2b Employer Identification Number (EIN) 23-7401847 2c Plan Sponsor's telephone number 314-835-2700 2d Business code (see instructions) 525100

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

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

SIGN HERE		<u>6.13.2025</u>	DAVID COOK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	4b EIN
a Sponsor's name	4d PN
c Plan Name	

5 Total number of participants at the beginning of the plan year	5	5,906
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a (1) Total number of active participants at the beginning of the plan year	6a(1)	5,724
a (2) Total number of active participants at the end of the plan year	6a(2)	5,385
b Retired or separated participants receiving benefits	6b	118
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	5,503
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g (1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	56

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F 4H

9a Plan funding arrangement (check all that apply)	9b 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)

a Pension Schedules

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

b General Schedules

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

United Food & Commercial Workers Union Local No. 655, Health & Welfare Fund
EIN: 23-7401847 Plan Number: 501
Schedule H, Line 4j - Schedule of Reportable Transactions
Year Ended August 31, 2024

Identity of Party Involved (a)	Description of Asset (b)	Purchase Price (c)	Selling Price (d)	Cost of Asset (g)	Current Value of Asset on Transaction Date (h)	Net Gain (Loss) (i)
<u>Series of transactions involving securities of the same issue in excess of 5%:</u>						
Baird Core Plus Bond Instl Class	Baird Core Plus Bond Inst Class (3)	\$ -	\$ 2,500,030	\$ 2,681,341	\$ 2,500,030	\$ (181,311)