

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110  
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

- A This return/report is for: [X] 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. . . . . [X]
D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program [ ] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUS
1b Three-digit plan number (PN) ▶ 501
1c Effective date of plan 10/01/1974
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) TRUSTEES OF SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST
200 EAST RANDOLPH ST., SUITE 1500 CHICAGO, IL 60601-4200
2b Employer Identification Number (EIN) 36-2857218
2c Plan Sponsor's telephone number 312-233-8800
2d Business code (see instructions) 561790

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include GENIE KASTRUP (plan administrator), DAVID HOPWOOD (employer/plan sponsor), and a row for DFE.

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

Form 5500 (2023) v. 230707

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	11847
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ..... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	11830
	<b>6a(2)</b>	11772
	<b>6b</b>	12
	<b>6c</b>	0
	<b>6d</b>	11784
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	148

**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 4D 4E 4F

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

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

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

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

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**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.

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**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 \_\_\_\_\_

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**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 **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUS</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>36-2857218</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**BLUE CROSS BLUE SHIELD OF ILLINOIS**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>36-1236610</b>	<b>70670</b>	<b>D77000</b>	<b>11910</b>	<b>08/01/2023</b>	<b>07/31/2024</b>

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

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

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

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

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

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

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

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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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

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

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year.....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

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

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

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

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

<b>b</b> Balance at the end of the previous year .....		<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>		
	<b>7c(2)</b>		
	<b>7c(3)</b>		
	<b>7c(4)</b>		
	<b>7c(5)</b>		
(6) Total additions .....		<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....		<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>		
	<b>7e(2)</b>		
	<b>7e(3)</b>		
	<b>7e(4)</b>		
	(5) Total deductions .....		
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....		<b>7f</b>	

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier.....	<b>10a</b>	2978309
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

**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 **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUS</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUST</b>		<b>D</b> Employer Identification Number (EIN) <b>36-2857218</b>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**UNION HEALTH SERVICE, INC.**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>36-2302593</b>	<b>52553</b>	<b>LOCAL 1 HEALTH</b>	<b>11808</b>	<b>01/01/2023</b>	<b>12/31/2023</b>

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

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

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

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year.....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	<b>7e(5)</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	49638520
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUS</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>36-2857218</b>	

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

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

**THE VANGUARD GROUP INC.**

**23-1945930**

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

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

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

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

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

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

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

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

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

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

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**(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)

BLUE CROSS BLUE SHIELD OF ILLINOIS

36-1236610

(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 56 73	NONE	3751430	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ASHER, GITTLER & D'ALBA, LTD.

36-2786883

(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	307136	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AMALGAMATED BANK OF CHICAGO

36-0721895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 51 62	NONE	269080	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input 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)

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

(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	199420	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LEGACY PROFESSIONALS LLP

32-0043599

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 15	NONE	194353	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)

M. PIZARRO

36-2857218

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14	ADMINISTRATOR	159742	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)

K. FARIAS

36-2857218

(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	EMPLOYEE	133605	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)

A. PERRY

36-2857218

(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	EMPLOYEE	116498	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)

L. DOPORCYK

36-2857218

(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	EMPLOYEE	110474	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)

K. BAKER

36-2857218

(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	EMPLOYEE	107712	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)

D. GARCIA

36-2857218

(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	EMPLOYEE	94358	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)

M. RAIMONDI

36-2857218

(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	EMPLOYEE	93319	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)

A. DOBRZYNIECKI

36-2857218

(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	EMPLOYEE	91425	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)

BENEFITS MANAGEMENT GROUP, INC.

20-0188125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 36	NONE	85856	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)

J. HERRERA

36-2857218

(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	EMPLOYEE	81297	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

S. CHAVEZ

36-2857218

(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	EMPLOYEE	79782	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)

M. FRICANO

36-2857218

(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	EMPLOYEE	78282	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)

TFBC, LLC

27-3782504

(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	78000	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)

Y. GONZALEZ

36-2857218

(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	EMPLOYEE	75144	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)

E. BAK

36-2857218

(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	EMPLOYEE	68189	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)

J. HYDZIK

36-2857218

(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	EMPLOYEE	62873	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)

J. LUCERO

36-2857218

(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	EMPLOYEE	62642	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)

D. LIRA

36-2857218

(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	EMPLOYEE	59914	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)

A. LENARD

36-2857218

(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	EMPLOYEE	58776	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)

M. VALDOVINOS

36-2857218

(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	EMPLOYEE	53994	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)

C. O'BRIEN

36-2857218

(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	EMPLOYEE	53153	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)

L. HYNES

36-2857218

(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	EMPLOYEE	42911	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)

N. DEL CID

36-2857218

(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	EMPLOYEE	40623	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)

A. BAEZ

36-2857218

(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	EMPLOYEE	34729	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)

D. BRATEK

36-2857218

(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	EMPLOYEE	33545	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)

SOMMERS & FAHRENBACH, INC.

36-1796440

(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 38	NONE	30704	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)

BENESYS INC.

38-2383171

(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	27965	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)

TAB SERVICE COMPANY

36-2463139

(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	25698	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)

K-PLUS COMPUTER SERVICES, LLC

36-4282001

(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	18000	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)

COZEN O'CONNOR

23-1732832

(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	11481	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)

MORGAN, LEWIS, & BOCKIUS LLP

23-0891050

(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	10212	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)

CBRE, INC.

95-2743174

(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	7000	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)

UNION INSURANCE GROUP

36-4226088

(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?
22 53	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input checked="" 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
UNION INSURANCE GROUP	22	0
(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.	
CHUBB/FEDERAL INSURANCE CO.  22-3253301	COMMISSIONS - 15% OF FIDUCIARY LIABILITY PREMIUMS	
(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.

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUS</b>	<b>B</b> Three-digit plan number (PN) <b>►</b> <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF SEIU LOCAL 1 &amp; PARTICIPATING EMPLOYERS HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>36-2857218</b>

**Part I Asset and Liability Statement**

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

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	-102295	-4080178
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	11221762	11835392
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	1116320	6133323
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>		
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>	79805496	94629210
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>	45895769	44868316
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	14311758	18104742
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>	8732678	8701410
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	160981488	180192215
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>	10897000	12017000
<b>h</b> Operating payables .....	<b>1h</b>	237789	178409
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>		519226
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	11134789	12714635
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	149846699	167477580

**Part II Income and Expense Statement**

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

<b>Income</b>		<b>(a)</b> Amount	<b>(b)</b> Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>	139907873	
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	151007	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		140058880
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>		
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>	3724865	
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>	1528526	
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		5253391
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>	550092	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		550092
<b>(3)</b> Rents .....	<b>2b(3)</b>		731232
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>	95800725	
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>	95141326	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		659399
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>	4800094	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts.....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts.....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities.....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		3806449
<b>c</b> Other income .....	<b>2c</b>		1617362
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		157476899

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	1179355	
(2) To insurance carriers for the provision of benefits.....	<b>2e(2)</b>	52200613	
(3) Other.....	<b>2e(3)</b>	82648801	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		136028769
<b>f</b> Corrective distributions (see instructions).....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	<b>2i(1)</b>	1866438	
(2) Contract administrator fees.....	<b>2i(2)</b>		
(3) Recordkeeping fees.....	<b>2i(3)</b>	101496	
(4) IQPA audit fees.....	<b>2i(4)</b>	92857	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	257378	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	11702	
(7) Actuarial fees .....	<b>2i(7)</b>		
(8) Legal fees .....	<b>2i(8)</b>	328829	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>	8662	
(11) Other expenses .....	<b>2i(11)</b>	1149887	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		3817249
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		139846018

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		17630881
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**Part III Accountant's Opinion**

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

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

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

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

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

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

(1) Name: LEGACY PROFESSIONALS LLP

(2) EIN: 32-0043599

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

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

**Part IV Compliance Questions**

**4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

**SEIU Local 1 & Participating Employers  
Health Trust**

Financial Statements

September 30, 2024

**SEIU Local 1 & Participating Employers  
Health Trust**

Financial Statements with Supplementary Information

September 30, 2024 and 2023

**Contents**

	Page
Report of Independent Auditors	1
Statements of Net Assets Available for Benefits	3
Statements of Changes in Net Assets Available for Benefits	4
Statements of Benefit Obligations	5
Statements of Changes in Benefit Obligations	6
Notes to Financial Statements	7
Supplementary Information	Schedule
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)	1
Schedule H, Line 4j - Schedule of Reportable Transactions	2

## **Report of Independent Auditors**

To the Participants and Trustees of  
SEIU Local 1 & Participating Employers  
Health Trust

### ***Opinion***

We have audited the financial statements of SEIU Local 1 & Participating Employers Health Trust (the Plan), 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 September 30, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of SEIU Local 1 & Participating Employers Health Trust as of September 30, 2024 and 2023, and the changes in its net assets available for benefits and 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 Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence that 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 Plan's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

***Responsibilities of Management for the Financial Statements (continued)***

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

***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 Plan'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; and
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan'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.

*Legacy Professionals LLP*

Westchester, Illinois

April 15, 2025

**SEIU Local 1 & Participating Employers  
Health Trust**

**Statements of Net Assets Available for Benefits**

September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Assets</b>		
Investments - at fair value		
Fixed income securities	\$ 139,497,526	\$ 125,701,265
Mutual funds	<u>18,104,742</u>	<u>14,311,758</u>
Total investments	<u>157,602,268</u>	<u>140,013,023</u>
Cash	<u>21,962</u>	<u>120,799</u>
Receivables		
Employer contributions - net	11,835,392	11,221,762
Accrued interest and dividends	1,270,505	1,030,211
Due from related organizations - net	-	4,245
Due from broker	3,171,840	-
Transitional reinsurance fee refund	1,173,416	-
Other	<u>2,290</u>	<u>184</u>
Total receivables	<u>17,453,443</u>	<u>12,256,402</u>
Prepaid expenses		
Prepaid medical premiums - Union Health Service	433,000	-
Other	<u>82,272</u>	<u>81,680</u>
Total prepaid expenses	<u>515,272</u>	<u>81,680</u>
Property and equipment - net	<u>164,467</u>	<u>198,748</u>
Total assets	<u>175,757,412</u>	<u>152,670,652</u>
<b>Liabilities and Net Assets</b>		
Liabilities		
Bank overdraft	4,102,140	223,094
Due to related organizations	65,420	-
Accounts payable and accrued expenses	178,409	237,789
Deferred income	<u>453,806</u>	<u>-</u>
Total liabilities	<u>4,799,775</u>	<u>460,883</u>
Net assets available for benefits	<u>\$ 170,957,637</u>	<u>\$ 152,209,769</u>

See accompanying notes to the financial statements.

**SEIU Local 1 & Participating Employers  
Health Trust**

**Statements of Changes in Net Assets Available for Benefits**

Years Ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Additions</b>		
Investment income		
Net appreciation in fair value of investments	\$ 9,262,929	\$ 1,397,439
Interest and dividends	5,803,483	4,582,894
	15,066,412	5,980,333
Less investment expenses	(257,378)	(237,964)
Net investment income - net	14,809,034	5,742,369
Employer contributions	139,907,873	139,262,678
COBRA contributions	151,007	201,983
Liquidated damages	416,339	238,068
Transitional reinsurance fee refund	1,173,416	-
Income from rental operations	731,232	723,096
Other income	27,607	176,007
Total additions	157,216,508	146,344,201
<b>Deductions</b>		
Cost of benefits		
Medical	77,777,371	75,484,881
Disability	1,179,355	1,174,686
Union Health Service medical premiums	41,724,618	41,058,131
Union Health Service prescription drug premiums	7,499,079	7,677,788
Dental premiums	2,976,916	3,021,429
PPO network access fees	3,751,430	3,268,842
Cost containment administration fees	-	41
Total cost of benefits	134,908,769	131,685,798
Fees mandated by ACA	63,867	60,208
Administrative expenses	3,496,004	3,272,028
Total deductions	138,468,640	135,018,034
<b>Net increase</b>	18,747,868	11,326,167
<b>Net assets available for benefits</b>		
Beginning of year	152,209,769	140,883,602
End of year	\$ 170,957,637	\$ 152,209,769

See accompanying notes to the financial statements.

**SEIU Local 1 & Participating Employers  
Health Trust**

**Statements of Benefit Obligations**

September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Amounts currently payable</b>		
Claims payable and claims incurred but not reported	\$ 12,017,000	\$ 10,792,000
Union Health Service premiums payable	<u>                  -</u>	<u>          105,000</u>
Total amounts currently payable	<u>12,017,000</u>	<u>10,897,000</u>
 <b>Other obligations for current benefit coverage, at estimated amounts</b>		
Accumulated eligibility credits	<u>1,859,000</u>	<u>1,899,000</u>
 <b>Postretirement benefit obligations</b>		
Current retirees	2,557,483	2,306,611
Other participants fully eligible for benefits	2,200,985	1,965,548
Other participants not yet fully eligible for benefits	<u>2,732,681</u>	<u>3,279,195</u>
Total postretirement benefit obligations	<u>7,491,149</u>	<u>7,551,354</u>
 <b>Total benefit obligations</b>	 <u>\$ 21,367,149</u>	 <u>\$ 20,347,354</u>

See accompanying notes to the financial statements.

**SEIU Local 1 & Participating Employers  
Health Trust**

**Statements of Changes in Benefit Obligations**

Years Ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Amounts currently payable</b>		
Balance at beginning of year	\$ 10,897,000	\$ 10,791,000
Increase (decrease) during the year attributable to changes in		
Claims payable and claims incurred but not reported	1,225,000	538,000
Union Health Service premiums payable	<u>(105,000)</u>	<u>(432,000)</u>
Balance at end of year	<u>12,017,000</u>	<u>10,897,000</u>
<b>Other obligations for current benefit coverage, at estimated amounts</b>		
Balance at beginning of year	1,899,000	1,805,000
Increase (decrease) during the year attributable to changes in		
Accumulated eligibility credits	<u>(40,000)</u>	<u>94,000</u>
Balance at end of year	<u>1,859,000</u>	<u>1,899,000</u>
<b>Postretirement benefit obligations</b>		
Balance at beginning of year	7,551,354	9,764,073
Increase (decrease) during the year attributable to:		
Benefits earned and other changes	564,625	842,470
Actuarial experience (gain)	(520,786)	(650,163)
Changes in actuarial assumptions	<u>(104,044)</u>	<u>(2,405,026)</u>
Balance at end of year	<u>7,491,149</u>	<u>7,551,354</u>
<b>Total benefit obligations</b>	<u>\$ 21,367,149</u>	<u>\$ 20,347,354</u>

See accompanying notes to the financial statements.

# **SEIU Local 1 & Participating Employers Health Trust**

## **Notes to Financial Statements**

September 30, 2024 and 2023

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

SEIU Local 1 & Participating Employers Health Trust (the Plan) was established pursuant to a collective bargaining agreement between Service Employees' International Union Local No. 1 and the Building Owners and Managers' Association of Chicago. The Plan is a multiemployer welfare plan subject to provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan provides health benefits covering substantially all members of the building services division of Service Employees' International Union Local No. 1 (the Local). Participants are covered under either the Union Health Service, Inc. (UHS) and Hospital Coverage Plan (Plans 1 and 3) or the Indemnity Medical Plan (Plan 2). The Plan provides health benefits (hospital, surgical, major medical, prescription drug, dental and disability) covering eligible participants who work for a full month (173.32 hours). Participants become eligible in the fourth month of having contributions made on their behalf.

Participants continue to be covered under the Plan as long as an average of 120 hours per month is worked in covered employment over a rolling ten-month period. Eligibility ceases if a participant has no credited hours in two consecutive months.

Continuation of health care benefits to persons who would otherwise lose those benefits due to certain events, as mandated by Consolidated Omnibus Budget Reconciliation Act (COBRA), has been adopted by the Plan.

Participants should refer to the summary plan description for more complete information.

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

**Method of Accounting** - The accompanying financial statements have been prepared using the accrual basis of accounting.

## **Note 2. Summary of Significant Accounting Policies (continued)**

**New Accounting Pronouncement** - In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-13, *Financial Instruments - Credit Losses* (Topic 326), which is effective for the Plan for the year ended September 30, 2024. This new standard provides financial statement users with more decision-useful information about the expected credit losses on financial instruments and other commitments to extend credit held by a reporting entity at each reporting date. The standard replaced the incurred loss impairment model with a methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. The standard had no material impact on the Plan's financial statements.

**Investments** - Investments are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (the exit price). Net appreciation or depreciation includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Purchases and sales of investments are reflected on a trade-date basis.

Interest income is recorded on the accrual basis. Dividend income is recorded on the ex-dividend date.

**Contributions Receivable** - Employer contributions due and unpaid prior to year end are recorded as contributions receivable. Employer contributions due as determined by payroll compliance audits are recorded upon settlement with the employer. Contributions receivable is shown net of an allowance for uncollectible accounts of \$78,000 at September 30, 2024 and \$11,000 at September 30, 2023, as determined by a review of historical losses, the aging of receivables and adjusted for management's assessment of current conditions, and reasonable and supportable forecasts regarding future events.

**Transitional Reinsurance Fee Refund** - The Plan opted into the transitional reinsurance fee class action lawsuit which challenged the legality of requiring self-insured multiemployer welfare plans to pay the transitional reinsurance fees as mandated by the Patient Protection and Affordable Care Act. Judgment in favor of the plaintiffs was entered in the United States Court of Federal Claims. As part of this judgment, the Plan was awarded a total recovery in the amount of \$1,173,416 and recorded such amount as a receivable as of September 30, 2024.

**Prepaid Expenses** - Prepaid expenses include medical premiums paid in advance of the corresponding benefit month.

## **Note 2. Summary of Significant Accounting Policies (continued)**

**Property and Equipment** - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation and amortization are computed by the straight-line method over the following estimated useful lives:

Building	49 - 50 years
Building improvements	15 - 49 years
Computer hardware and software	3 - 5 years
Office equipment	5 - 7 years

**Deferred Income** - Employer and participant contributions received in advance of the corresponding eligibility period are recognized as deferred income.

**Benefit Obligations** - Benefit obligations are estimated by the Plan's actuarial and benefit consultants using accepted actuarial principles, based on paid and incurred claims cost studies, Plan benefits, and other data as considered necessary. Accumulated eligibility credits represent an estimate of claims which will be due the following year for participants credited with sufficient contributions prior to September 30 to maintain eligibility after year end.

**Revenue Recognition** - Revenue derived from employer contributions is recognized in the period in which covered work is performed, based on the number of hours worked in covered employment and the contribution rates set forth in the collective bargaining agreements. Employers are required to remit contributions monthly. The Plan carries out its purpose described in Note 1 within a jurisdiction primarily located in Chicago and surrounding areas of Illinois.

**Leases as Lessor** - The Plan leases office space to a related party as described in Note 10. Due to the immaterial nature of the amounts received pursuant to the leasing agreement, the Plan has not adopted the provisions of accounting guidance for leases required by generally accepted accounting principles (GAAP). The Plan recognizes rental income when rent payments are received. Under GAAP, rental income would be recognized on the straight-line basis.

**Expenses** - Certain investment related expenses are included in net appreciation in fair value of investments.

**Leases as Lessee** - Arrangements for shared office space with a related party are described in Note 12. Due to the immaterial nature of the amounts owed pursuant to the leasing agreement, the Plan has not adopted the provisions of accounting guidance for leases required by GAAP, which require that operating leases be included as a right-of-use (ROU) asset and a corresponding lease liability in the statements of net assets available for benefits. However, the Plan has included in the accompanying financial statements informative disclosures about the Plan's operating lease, including relevant terms, and monthly lease payments.

## **Note 2. Summary of Significant Accounting Policies (continued)**

**Estimates** - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

**Subsequent Events** - Subsequent events have been evaluated through April 15, 2025, which is the date the financial statements were available to be issued.

## **Note 3. Priorities upon Termination**

It is the intent of the Trustees to continue the Plan in full force and effect; however, in order to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan.

## **Note 4. Tax Status**

The Plan obtained a notice of exemption, in which the Internal Revenue Service stated that the trust established under the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code (IRC). The Plan has been amended since receiving the notice of exemption. The Plan's administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code, and therefore believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require the Plan to evaluate tax positions taken and recognize a tax liability if the Plan has taken uncertain tax positions that more likely than not would not be sustained upon examination by tax authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

## **Note 5. Funding Policy**

The Plan is primarily funded by contributions from employers at rates specified in the collective bargaining agreements. The hourly contribution rate in effect during the years ended September 30, 2024 and 2023 ranged from \$5.33 to \$6.48.

In addition, participant contributions are allowed to provide benefits under COBRA. COBRA monthly contribution rates are determined annually based on claims experience and ranged from \$453 to \$2,381 during the years ended September 30, 2024 and 2023, depending on the participant's coverage option.

## **Note 6. Concentration of Cash**

The Plan maintains its cash balances at one financial institution that is deemed to be creditworthy. Balances are insured by the FDIC up to \$250,000. Balances may at times exceed insured limits.

## **Note 7. Fair Value Measurements**

The *Fair Value Measurements and Disclosures* Topic of the FASB Accounting Standards Codification established a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below:

### Basis of Fair Value Measurement

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities
Level 2	Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly
Level 3	Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable

## Note 7. Fair Value Measurements (continued)

The following tables set forth, by level within the fair value hierarchy, the Plan's total investment assets at fair value as of September 30, 2024 and 2023. As required, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

	<u>Total</u>	<u>Fair Value Measurements at 9/30/24 Using</u>		
		<u>Quoted Prices</u> in Active Markets for Identical Assets <u>(Level 1)</u>	<u>Significant</u> Other Observable Inputs <u>(Level 2)</u>	<u>Significant</u> Unobservable Inputs <u>(Level 3)</u>
Fixed income securities:				
U.S. Treasury bills and notes	\$ 22,825,661	\$ 22,825,661	\$ -	\$ -
U.S. Government Agency obligations	65,312,233	-	65,312,233	-
Mortgage-backed securities	6,491,316	-	6,491,316	-
Corporate bonds and notes	44,868,316	-	44,868,316	-
	<u>139,497,526</u>	<u>22,825,661</u>	<u>116,671,865</u>	<u>-</u>
Mutual funds	<u>18,104,742</u>	<u>18,104,742</u>	<u>-</u>	<u>-</u>
Total	<u>\$ 157,602,268</u>	<u>\$ 40,930,403</u>	<u>\$ 116,671,865</u>	<u>\$ -</u>

	<u>Total</u>	<u>Fair Value Measurements at 9/30/23 Using</u>		
		<u>Quoted Prices</u> in Active Markets for Identical Assets <u>(Level 1)</u>	<u>Significant</u> Other Observable Inputs <u>(Level 2)</u>	<u>Significant</u> Unobservable Inputs <u>(Level 3)</u>
Fixed income securities:				
U.S. Treasury bills and notes	\$ 21,497,258	\$ 21,497,258	\$ -	\$ -
U.S. Government Agency obligations	54,326,846	-	54,326,846	-
Mortgage-backed securities	3,981,392	-	3,981,392	-
Corporate bonds and notes	45,895,769	-	45,895,769	-
	<u>125,701,265</u>	<u>21,497,258</u>	<u>104,204,007</u>	<u>-</u>
Mutual funds	<u>14,311,758</u>	<u>14,311,758</u>	<u>-</u>	<u>-</u>
Total	<u>\$ 140,013,023</u>	<u>\$ 35,809,016</u>	<u>\$ 104,204,007</u>	<u>\$ -</u>

### Level 1 Measurements

U.S. Treasury securities are traded in active markets on national securities exchanges and are valued at closing prices on the last business day of each period presented.

The fair values of the mutual funds are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value as of the last business day of each period presented.

## Note 7. Fair Value Measurements (continued)

### Level 2 Measurements

U.S. Government Agency obligations, mortgage-backed securities and corporate bonds and notes are generally valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. To the extent that quoted prices are not available, fair value is determined based on a valuation model that include inputs such as interest rate yield curves and credit spreads. Securities traded in markets that are not considered active are valued based on quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency. Securities that trade infrequently and therefore have little or no price transparency are valued using the investment manager's best estimates.

## Note 8. Property and Equipment

Property and equipment at September 30, 2024 and 2023 consisted of the following:

	<u>2024</u>	<u>2023</u>
Land	\$ 60,669	\$ 60,669
UHS Medical Facility:		
Building	3,191,768	3,191,768
Improvements	740,164	740,164
Plan Office:		
Computer hardware	27,621	27,621
Computer software	319,514	319,514
Office equipment	<u>40,879</u>	<u>40,879</u>
	4,380,615	4,380,615
Less accumulated depreciation and amortization	<u>(4,216,148)</u>	<u>(4,181,867)</u>
Net property and equipment	<u>\$ 164,467</u>	<u>\$ 198,748</u>

Depreciation and amortization expense was \$34,282 and \$23,182 for the years ended September 30, 2024 and 2023, respectively.

## **Note 9. Postretirement Benefit Obligations**

The Plan provides a health care benefit (hospital, surgical, major medical, prescription drug and dental) to certain eligible participants who have retired from active service.

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to Plan employee service rendered to September 30. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated Plan employees and their beneficiaries and dependents and (2) active Plan employees and their beneficiaries and dependents after retirement from service with the Plan. Prior to an active Plan employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that Plan employee's service in the Plan rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims cost data to estimate future annual incurred claims costs per Plan employee 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 actuarial valuation was prepared using the projected unit credit actuarial cost method.

The following were significant assumptions used in the valuations as of September 30, 2024 and 2023:

Mortality rate - RP-2014 Healthy Mortality Table projected for mortality improvement in years beyond 2014 using projection scale MP-2019

Average retirement age - 65

Weighted-average discount rate:

2024 - 5.03%

2023 - 5.56%

For measurement purposes, a 6.00% annual rate of increase in the per capita cost of covered health care benefits was assumed for both 2024 and 2023; the rate was assumed to decrease to 5.00% after one year, and to remain at that level thereafter.

The trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percent each year, it would increase the postretirement benefit obligations by \$2,045,756 and \$1,698,831 as of September 30, 2024 and 2023, respectively.

**Note 9. Postretirement Benefit Obligations (continued)**

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

Valuation assumption changes decreased obligations by \$104,044 during the year ended September 30, 2024, primarily due to a decrease in expected claims rates and an actuarial experience gain.

Valuation assumption changes decreased obligations by \$2,405,026 during the year ended September 30, 2023, primarily due to increasing the discount rate from 4.90% to 5.56%.

The Plan empowers the Board of Trustees to modify the terms and conditions under which retiree eligibility may be maintained; therefore, the cost to the Plan can be reduced or eliminated prospectively by action of the Board of Trustees.

**Note 10. Office Leases (As Lessor)**

The Plan leases property to Union Health Service, Inc., (UHS) under an operating lease agreement which expires on December 31, 2027. The lease includes renewal options for three additional periods of five years each, based on certain terms and conditions. Rental income was \$731,232 and \$723,096 for the years ended September 30, 2024 and 2023, respectively.

A summary by year of future minimum rental income under the UHS lease agreement is as follows:

Year ending September 30,	
2025	\$ 750,459
2026	772,974
2027	796,158
2028	<u>200,499</u>
Total	<u>\$ 2,520,090</u>

**Note 11. Employee Benefit Plans**

401(k) Plan

The Plan maintains a 401(k) plan that covers employees who meet eligibility requirements. The 401(k) plan is a safe harbor profit sharing retirement plan. Contributions under the 401(k) provisions represent salary reduction amounts elected by employees. The Plan contributes at least 3% of compensation for each eligible employee. Additional employer discretionary contributions are allowable. Total contributions to the 401(k) plan were \$36,612 and \$36,196 for the years ended September 30, 2024, and 2023, respectively.

## Note 11. Employee Benefit Plans (continued)

### Multiemployer Plans

#### *Defined Benefit Pension Plans*

Substantially all employees of the Plan are covered by two multiemployer defined benefit pension plans. The risk of participating in multiemployer defined benefit pension plans is different from single employer plans. Assets contributed to a multiemployer defined benefit pension plan by one employer may be used to provide benefits to employees of 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.

The Plan's shared participation in the multiemployer defined benefit pension plans for the years ended September 30, 2024 and 2023 is outlined in the following table. Plans that are considered to be significant are required to be identified. The "EIN/PN" column provides the employer identification number (EIN) and the three-digit plan number (PN). The most recent Pension Protection Act (PPA) zone status provides an indication of the financial health of the plan. Among other factors, plans in the red zone are below 65 percent funded, plans in the yellow zone are between 65 percent and 80 percent funded, and plans in the green zone are at least 80 percent funded. The last column specifies the year end date of the plan to which the annual report (Form 5500) relates.

Pension Plan	EIN/PN	Pension Protection Act Zone Status		Contributions		Most Recently Available Annual Report (Form 5500)
		2024	2023	2024	2023	
SEIU Affiliates Officers and Employees Pension Plan	52-0812348/001	Green as of 1/1/2024	Green as of 1/1/2023	\$ 249,063	\$ 247,893	12/31/2023
SEIU Local 1 & Participating Employers Pension Trust	36-6486542/001	Green as of 10/1/2024	Green as of 10/1/2023	<u>41,296</u>	<u>41,787</u>	9/30/2023
				<u>\$ 290,359</u>	<u>\$ 289,680</u>	

Contributions are made monthly under the terms of participation agreements, which do not have an expiration date. The Plan's contributions do not represent more than 5% of total contributions to the plans as indicated in the plans' most recently available annual reports.

#### *Welfare Plan that Provides Postretirement Benefits*

Certain Plan employees were covered by a multiemployer welfare plan that provided medical benefits to retirees and to eligible employees working under collective bargaining agreements, and their dependents. Effective January 1, 2023, such employees began to be covered by a different multiemployer welfare plan that does not provide medical benefits to retirees. Contributions for the year ended September 30, 2023 totaled \$41,944.

## **Note 12. Related Party and Party-in-Interest Transactions**

The Plan is related to Service Employees' International Union Local No. 1 (the Local) and SEIU Local No. 1 & Participating Employers Pension Trust (the Pension Plan).

### Office Lease - as Lessee

The Plan has a sublease agreement with the Local for the rental of common office space in Chicago, Illinois, which required monthly payments of \$12,638 at October 1, 2024. The Plan is also required to pay a proportionate share of real estate taxes and operating costs of the building. As a lease incentive, rent was abated for 12 months spread over the first four years of the agreement. Rent expense, including common operating expenses and real estate taxes, totaled \$150,242 and \$148,852 for the years ended September 30, 2024 and 2023, respectively.

In addition, certain common operating expenses are paid by the Local and allocated to the Plan. The allocated expenses totaled \$25,381 and \$26,834 for the years ended September 30, 2024 and 2023, respectively. The amount due to the Local totaled \$43,462 and \$33,488 at September 30, 2024 and 2023, respectively.

The office sublease agreement with the Local was set to expire on March 31, 2030. However, in March 2024, the Local exercised its available early termination option with the landlord of the office building. This space was being leased on a month-to-month basis through March 2025. In November 2024, the Plan signed a new sublease agreement with the Local effective in April 2025 for the rental of common office space at a new location in Chicago, Illinois which is set to expire on May 31, 2040. Monthly rent under this agreement is \$12,213 at commencement.

### Shared Administrative Expenses

Certain shared administrative expenses, mainly payroll costs, are initially paid by the Plan and are shared with the Pension Plan. These expenses are allocated based on estimates of employees' time. Other shared expenses are initially paid by the Plan and are allocated to the Pension Plan based on costs incurred. Shared expenses with the Pension Plan totaled \$1,233,729 and \$1,139,347 for the years ended September 30, 2024 and 2023, respectively. The amount due to the Pension Plan totaled \$21,958 at September 30, 2024. The amount due from the Pension Plan totaled \$37,733 at September 30, 2023.

### Party-in-Interest Transactions

The Plan has a lease agreement with UHS (see Note 10). The Plan has contracted with UHS to provide medical services to the Plan's participants. UHS is also a contributing employer to the Plan. The Plan's administrator and the Plan's legal counsel believe that these transactions meet the conditions required to exempt these transactions from the prohibited transaction rules of ERISA.

### **Note 13. Major Employers**

Contributions from three employers accounted for approximately 40% of total employer contributions for the year ended September 30, 2024. Contributions from two employers accounted for approximately 30% of total employer contributions for the year ended September 30, 2023. In the event these employers were to suspend contributions, the Plan would terminate coverage to the employers' participants as required under the Plan document. The Plan would retain the risk of meeting current fixed administrative expenses until the appropriate adjustments were made.

### **Note 14. Risks and Uncertainties**

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

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

### **Note 15. Reconciliation of Financial Statements to Form 5500**

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 170,957,637	\$ 152,209,769
Less - benefit obligations currently payable	(12,017,000)	(10,897,000)
Add - fair value appreciation of building per appraisal	<u>8,536,943</u>	<u>8,533,930</u>
Net assets available for benefits per the Form 5500	<u>\$ 167,477,580</u>	<u>\$ 149,846,699</u>

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500 for the year ended September 30, 2024:

Total benefits paid per the financial statements	\$ 134,908,769
Add - amounts currently payable at end of year	12,017,000
Less - amounts currently payable at beginning of year	<u>(10,897,000)</u>
Total benefits paid per the Form 5500	<u>\$ 136,028,769</u>

**Note 15. Reconciliation of Financial Statements to Form 5500 (continued)**

The following is a reconciliation of the net increase in net assets available for benefits per the financial statements to the Form 5500 for the year ended September 30, 2024:

Net increase per the financial statements	\$ 18,747,868
Less - amounts currently payable at end of year	(12,017,000)
Add - amounts currently payable at beginning of year	10,897,000
Add - change in fair value of building per appraisal	<u>3,013</u>
Net increase per the Form 5500	<u>\$ 17,630,881</u>

REPORT OF INDEPENDENT AUDITORS ON SUPPLEMENTAL SCHEDULES

To the Participants and Trustees of  
SEIU Local 1 & Participating Employers  
Health Trust

We have audited the financial statements of SEIU Local 1 & Participating Employers Health Trust (the Plan) as of and for the years ended September 30, 2024 and 2023, and our report thereon dated April 15, 2025, which expressed an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audits were conducted for the purpose of forming an opinion on the financial statement as a whole. Supplemental Schedules 1 and 2 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 are 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.

*Legacy Professionals LLP*

Westchester, Illinois

April 15, 2025

SEIU LOCAL 1 & PARTICIPATING EMPLOYERS  
HEALTH TRUST  
EIN # 36-2857218  
SCHEDULE SUPPORTING FORM 5500 FOR 2023  
(FOR YEAR ENDED SEPTEMBER 30, 2024)  
SCHEDULE H, LINE 4i- SCHEDULE OF ASSETS HELD AT END OF YEAR

	<u>Shares/Units</u>	<u>Cost</u>	<u>Fair Value</u>
<u>U.S. GOVERNMENT SECURITIES</u>			
U.S. Treasury Bill, due 10/22/24	2,000,000	\$ 1,965,846	\$ 1,965,846
U.S. Treasury Bill, due 11/12/24	2,000,000	1,985,303	1,985,303
U.S. Treasury Notes, 3.125%, due 11/15/28	3,070,000	3,510,759	3,015,078
U.S. Treasury Notes, 4.125%, due 11/15/32	5,000,000	5,195,703	5,138,500
U.S. Treasury Notes, 4.625%, due 3/15/26	2,000,000	1,987,500	2,023,820
U.S. Treasury Notes, 5.000%, due 8/31/25	5,000,000	4,993,359	5,042,150
U.S. Treasury Notes, 4.875%, due 10/31/28	3,000,000	3,018,984	3,145,080
U.S. Treasury Notes, 4.625%, due 11/15/26	500,000	507,500	509,885
GNMA II MA9851 5.500%, due 8/20/54	2,595,043	2,633,969	2,620,241
Ginnie Mae II G2 MA8427 4.500%, due 11/20/52	2,752,698	2,737,644	2,719,940
Ginnie Mae II MA8726 5.500%, due 3/20/53	1,138,463	1,156,430	1,151,134
FFCB 3.430%, due 12/06/28	2,456,000	2,593,370	2,435,370
FFCB 4.250%, due 5/17/28	4,500,000	4,504,208	4,589,235
FFCB 5.125%, due 10/20/25	1,445,000	1,441,503	1,463,178
FFCB 4.750%, due 5/6/27	5,453,000	5,476,066	5,603,012
FFCB 4.750%, due 12/14/26	2,000,000	2,003,116	2,044,400
FFCB 4.500%, due 1/8/30	2,500,000	2,529,600	2,596,100
FFCB Callable 5.090%, due 5/20/31	2,080,000	2,080,000	2,140,819
FFCB Callable 4.370%, due 5/17/32	500,000	478,520	495,910
FFCB Callable 5.340%, due 3/12/29	2,534,000	2,530,123	2,537,851
FFCB Callable 4.85%, due 6/15/37	1,691,000	1,678,318	1,687,280
FFCB Callable 5.050%, due 7/28/28	750,000	748,125	754,335
FFCB Callable 5.240%, due 6/29/37	885,000	884,558	882,646
FFCB Floating Rate Note 5.863%, due 4/26/32	1,500,000	1,513,350	1,508,685
FHLB 4.625%, due 6/11/27	1,395,000	1,392,642	1,430,796
FHLB 4.875%, due 12/11/26	6,585,000	6,618,722	6,747,057
FHLB 4.750%, due 12/10/27	540,000	553,165	558,371
FHLB 4.500%, due 12/11/26	1,065,000	1,083,755	1,082,828
FHLB 4.500%, due 12/12/25	905,000	915,299	911,643
FHLB 4.625%, due 3/14/25	4,315,000	4,332,346	4,317,244
FHLB 4.750%, due 12/10/32	4,080,000	4,227,370	4,304,930
FHLB 4.500%, due 3/9/29	1,940,000	1,971,544	2,008,424
FHLB 4.750%, due 6/12/26	2,000,000	1,999,800	2,032,940
FHLB 4.500%, due 6/10/33	330,000	335,874	341,263
FHLB 4.500%, due 9/9/33	3,350,000	3,487,250	3,462,761
FHLB 4.875%, due 9/11/26	1,200,000	1,211,568	1,226,208
FHLB 5.125%, due 5/28/26	1,250,000	1,248,438	1,249,587
FHLB Callable 5.750%, due 5/13/31	765,000	765,000	770,554
FHLB Callable 5.000%, due 3/13/30	3,900,000	3,894,150	3,933,891
FHLB Callable 5.100%, due 2/15/28	685,000	684,658	690,391
FHLB Callable 5.000%, due 7/11/25	1,000,000	1,000,000	999,390
FHLB Callable 6.000%, due 10/11/28	500,000	500,250	500,270
FHLB Callable 4.030%, due 4/27/32	5,000	5,000	4,864
		<u>94,380,685</u>	<u>94,629,210</u>

SEIU LOCAL 1 & PARTICIPATING EMPLOYERS  
HEALTH TRUST  
EIN # 36-2857218  
SCHEDULE SUPPORTING FORM 5500 FOR 2023  
(FOR YEAR ENDED SEPTEMBER 30, 2024)  
SCHEDULE H, LINE 4i- SCHEDULE OF ASSETS HELD AT END OF YEAR

	<u>Shares/Units</u>	<u>Cost</u>	<u>Fair Value</u>
<u>CORPORATE BONDS</u>			
3M Company 2.375%, due 08/26/29	1,400,000	\$ 1,412,768	\$ 1,286,908
3M Company 2.875%, due 10/15/27	425,000	430,359	410,019
3M Company 3.050%, due 04/15/30	295,000	308,853	279,642
Bank of America Corp Variable Rate 6.204%, due 11/10/28	890,000	885,239	939,172
Bank of New York Mellon Corp 3.000%, due 10/30/28	1,400,000	1,480,570	1,334,872
Berkshire Hathaway Inc. 3.125%, due 03/15/26	2,025,000	2,171,120	2,000,214
Caterpillar Financial Service 2.150%, due 11/08/24	1,050,000	1,102,384	1,046,787
Caterpillar Inc. 2.600%, due 09/19/29	1,700,000	1,736,567	1,590,707
Citigroup Inc. 3.300%, due 04/27/25	1,250,000	1,292,250	1,239,513
Citigroup Inc. Variable Rate Bond 4.075%, due 4/23/29	1,000,000	1,017,700	989,470
Comcast Corp 2.350%, due 01/15/27	1,000,000	1,078,790	963,850
Comerica Inc. 4.000%, due 02/01/29	475,000	495,083	459,714
Duke Energy Corp 2.650%, due 09/01/26	1,000,000	1,008,750	972,240
Exxon Mobil Corp 3.043%, due 03/01/26	2,200,000	2,280,850	2,173,292
Florida Power & Light 5.100%, due 04/01/33	175,000	178,201	182,915
Georgia Power Co 2.650%, due 09/15/29	805,000	822,976	751,009
Goldman Sachs Group Inc. 3.500%, due 01/23/25	250,000	274,675	248,865
Goldman Sachs Group Inc. 3.500%, due 11/16/26	1,000,000	990,600	984,900
Interstate Power & Light 3.400%, due 08/15/25	1,500,000	1,499,970	1,484,850
John Deere Capital Corp 2.800%, due 09/08/27	975,000	1,001,812	943,829
JPM Chase & Co 3.300%, due 04/01/26	1,955,000	2,084,611	1,930,250
JPM Chase & Co 5.717%, due 9/14/33	1,200,000	1,187,244	1,271,232
Morgan Stanley 4.000%, due 07/23/25	1,150,000	1,145,135	1,146,240
Nevada Power Co 2.400%, due 05/01/30	900,000	963,477	815,103
Oracle Corp 2.650%, due 07/15/26	2,715,000	2,835,630	2,638,356
Oracle Corp 2.950%, due 11/15/24	300,000	320,889	299,202
PepsiCo Inc. 2.850% 2/24/26	1,100,000	1,117,270	1,084,402
Philip Morris Intl 2.100%, due 05/01/30	1,000,000	1,033,330	892,010
PNC Bank 2.700%, due 10/22/29	2,500,000	2,696,600	2,288,875
PNC Financial Services 2.550%, due 01/22/30	2,000,000	2,049,520	1,833,200
Private Export FDG Corp 3.900%, due 10/15/27	293,000	292,531	294,951
Private Export FDG Corp 4.600%, due 2/15/34	1,000,000	997,350	1,015,030
State Street Corp 2.400%, due 01/24/30	1,500,000	1,516,500	1,382,775
Verizon Communications 2.625%, due 08/15/26	1,000,000	1,017,880	971,910
Verizon Communications 5.050%, due 05/09/33	1,300,000	1,325,545	1,340,521
Wells Fargo Bank & Co Variable Rate 3.196%, due 06/17/27	2,205,000	2,222,750	2,162,421
Wisconsin Electric Power 2.050%, due 12/15/24	3,240,000	3,355,008	3,219,070
		<u>47,630,787</u>	<u>44,868,316</u>
<u>MUTUAL FUNDS</u>			
Goldman Financial Square Treasury Obligations Fund	2,634,693	2,634,693	2,634,693
Vanguard Institutional Index Fund	32,627	8,222,625	15,470,049
		<u>10,857,318</u>	<u>18,104,742</u>
		<u>\$ 152,868,790</u>	<u>\$ 157,602,268</u>

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 1

NAME	SERVICE CODES
BLUE CROSS BLUE SHIELD OF ILLINOIS	12
BLUE CROSS BLUE SHIELD OF ILLINOIS	13
BLUE CROSS BLUE SHIELD OF ILLINOIS	56
BLUE CROSS BLUE SHIELD OF ILLINOIS	73
AMALGAMATED BANK OF CHICAGO	19
AMALGAMATED BANK OF CHICAGO	28
AMALGAMATED BANK OF CHICAGO	51
AMALGAMATED BANK OF CHICAGO	62

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 2

DESCRIPTION	BEGINNING	ENDING
ACCRUED INTEREST AND DIVIDENDS	1,030,211.	1,270,505.
DUE FROM RELATED ORGANIZATIONS - NET	4,245.	0.
OTHER RECEIVABLES	184.	2,290.
PREPAID EXPENSES - OTHER	81,680.	82,272.
DUE FROM BROKER	0.	3,171,840.
TRANSITIONAL REINSURANCE FEE REFUND	0.	1,173,416.
PREPAID UHS MEDICAL PREMIUMS	0.	433,000.
TOTAL TO SCHEDULE H, LINE 1B(3)	1,116,320.	6,133,323.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
DEFERRED INCOME	0.	453,806.
DUE TO RELATED ORGANIZATIONS	0.	65,420.
TOTAL TO SCHEDULE H, LINE 1J	0.	519,226.

SCHEDULE H	OTHER INCOME	STATEMENT 4
DESCRIPTION		AMOUNT
LIQUIDATED DAMAGES		416,339.
OTHER INCOME		27,607.
TRANSITIONAL REINSURANCE FEE REFUND		1,173,416.
TOTAL TO SCHEDULE H, LINE 2C		1,617,362.

SCHEDULE H	OTHER PAYMENTS TO PROVIDE BENEFITS	STATEMENT 5
DESCRIPTION		AMOUNT
MEDICAL CLAIMS		77,777,371.
PPO NETWORK ACCESS FEES		3,751,430.
CHANGE IN CLAIMS PAYABLE		1,120,000.
TOTAL TO SCHEDULE H, LINE 2E(3)		82,648,801.

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT 6
DESCRIPTION		AMOUNT
CONSULTING FEES - OTHER		16,386.
DUES AND SUBSCRIPTIONS		24,759.
INSURANCE		102,966.
MISCELLANEOUS		4,733.
OFFICE PARKING EXPENSE		5,083.
SOFTWARE MAINTENANCE		305,920.
OFFICE SUPPLIES AND EXPENSE		97,553.
STAFF TRAINING AND DEVELOPMENT		9,199.
SERVICE CHARGES AND FEES		1,371.
PRINTING AND POSTAGE		115,248.
FEES MANDATED BY ACA		63,867.
DEPRECIATION AND AMORTIZATION		34,282.
OFFICE RENT		150,242.
HARDWARE MAINTENANCE		18,000.
PAYROLL TAXES		96,502.
BENEFIT CONSULTANT FEES		78,000.
CONFERENCE, CONVENTIONS AND MEETINGS		25,776.
TOTAL TO SCHEDULE H, LINE 2I(11)		1,149,887.

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110  
1210 - 0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

- A This return/report is for: [X] a multiemployer plan [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is: [ ] a single-employer plan [ ] a DFE (specify)
[ ] the first return/report [ ] the final return/report
[ ] an amended return/report [ ] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here [X]
D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program
[ ] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here [ ]

Part II Basic Plan Information - enter all requested information

1a Name of plan: SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUS
1b Three-digit plan number (PN): 501
1c Effective date of plan: 10/01/1974
2a Plan sponsor's name (employer, if for a single-employer plan): TRUSTEES OF SEIU LOCAL 1 & PARTICIPATING EMPLOYERS
2b Employer Identification Number (EIN): 36-2857218
2c Plan Sponsor's telephone number: 312-233-8800
2d Business code (see instructions): 561790

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include Genie Kastrup (Signature of plan administrator), David Hopwood (Signature of employer/plan sponsor), and a blank row for DFE.

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

Form 5500 (2023) v. 230728

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
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<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
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<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	11,847
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	11,830
<b>a (2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	11,772
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	12
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	0
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c	<b>6d</b>	11,784
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e	<b>6f</b>	
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	148

**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 4D 4E 4F**

<b>9a</b> Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

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



## TRADE DATE - INCOME ACCRUALS

Statement Period

10/01/23 through 09/30/24

SEIU LOCAL 1 & PARTICIPATING  
 EMPLOYERS HEALTH TRUST  
 (FORMERLY LOCAL 25 SEIU WELFARE)

### Schedule Of Reportable Transactions

DESCRIPTION	TRAN TYPE	SETTLE DATE/ SHARES/UNITS	PURCHASE/SALE COST/PROCEEDS	BROKER COMMISSION/ OTH EXPENSE	COST OF ASSET/ PREV ANNL MKT	NET GAIN/LOSS
CUSIP # 912797FJ1 TREASURY BILL 11/09/2023	BUY	10/20/23 3,425,000.000	3,414,953.33		3,414,953.33 3,414,953.33	
	SEL	11/07/23 4,000,000.000	3,998,828.88		3,974,122.66 3,974,122.66	24,706.22
	MAT	11/09/23 1,400,000.000	1,390,942.93		1,390,942.93 1,390,942.93	
<b>1 PURCHASES FOR</b>			<b>3,414,953.33</b>	<b>2 SALES FOR</b>		<b>8,804,725.14</b>
			<b>5,389,771.81</b>	<b>ISSUE AGGREGATE TOTAL</b>		
CUSIP # 912797HM2 TREASURY BILL 11/28/2023	BUY	11/22/23 3,000,000.000	2,997,375.00		2,997,375.00 2,997,375.00	
	MAT	11/28/23 5,045,000.000	5,006,982.86		5,006,982.86 5,006,982.86	
<b>1 PURCHASES FOR</b>			<b>2,997,375.00</b>	<b>1 SALES FOR</b>		<b>8,004,357.86</b>
			<b>5,006,982.86</b>	<b>ISSUE AGGREGATE TOTAL</b>		
CUSIP # 912797JA6 TREASURY BILL 01/23/2024	BUY	12/22/23 5,000,000.000	4,976,644.44		4,976,644.44 4,976,644.44	
	SEL	01/04/24 1,000,000.000	997,213.33		995,328.89 995,328.89	1,884.44
	SEL	01/09/24 1,000,000.000	997,950.56		995,328.89 995,328.89	2,621.67
	MAT	01/23/24 3,000,000.000	2,985,986.66		2,985,986.66 2,985,986.66	
<b>1 PURCHASES FOR</b>			<b>4,976,644.44</b>	<b>3 SALES FOR</b>		<b>9,957,794.99</b>
			<b>4,981,150.55</b>	<b>ISSUE AGGREGATE TOTAL</b>		
CUSIP # 912797JG3 TREASURY BILL 03/05/2024	BUY	02/23/24 5,000,000.000	4,991,979.16		4,991,979.16 4,991,979.16	
	MAT	03/05/24 5,000,000.000	4,991,979.16		4,991,979.16 4,991,979.16	
<b>1 PURCHASES FOR</b>			<b>4,991,979.16</b>	<b>1 SALES FOR</b>		<b>9,983,958.32</b>
			<b>4,991,979.16</b>	<b>ISSUE AGGREGATE TOTAL</b>		
CUSIP # 912797JN8 TREASURY BILL 04/16/2024	BUY	01/19/24 285,000.000	281,387.78		281,387.78 281,387.78	
	BUY	02/21/24 4,025,000.000	3,992,593.16		3,992,593.16 3,992,593.16	
	SEL	04/03/24 2,500,000.000	2,495,237.85		2,479,107.27 2,479,107.27	16,130.58
	SEL	04/05/24 1,810,000.000	1,807,088.16		1,794,873.67 1,794,873.67	12,214.49
<b>2 PURCHASES FOR</b>			<b>4,273,980.94</b>	<b>2 SALES FOR</b>		<b>8,576,306.95</b>
			<b>4,302,326.01</b>	<b>ISSUE AGGREGATE TOTAL</b>		
CUSIP # 912797JS7 TREASURY BILL 07/18/2024	BUY	04/18/24 5,000,000.000	4,933,772.22		4,933,772.22 4,933,772.22	
	SEL	05/03/24 2,500,000.000	2,472,291.68		2,466,886.11 2,466,886.11	5,405.57
	SEL	05/08/24 1,500,000.000	1,484,483.54		1,480,131.67 1,480,131.67	4,351.87
	SEL	06/05/24 1,000,000.000	993,696.90		986,754.44 986,754.44	6,942.46
<b>1 PURCHASES FOR</b>			<b>4,933,772.22</b>	<b>3 SALES FOR</b>		<b>9,884,244.34</b>
			<b>4,950,472.12</b>	<b>ISSUE AGGREGATE TOTAL</b>		



**TRADE DATE - INCOME ACCRUALS**

Statement Period

10/01/23 through 09/30/24

SEIU LOCAL 1 & PARTICIPATING  
 EMPLOYERS HEALTH TRUST  
 (FORMERLY LOCAL 25 SEIU WELFARE)

**Schedule Of Reportable Transactions**

DESCRIPTION	TRAN TYPE	SETTLE DATE/ SHARES/UNITS	PURCHASE/SALE COST/PROCEEDS	BROKER COMMISSION/ OTH EXPENSE	COST OF ASSET/ PREV ANNL MKT	NET GAIN/LOSS
CUSIP # 912797KB2 TREASURY BILL 08/15/2024	BUY	05/16/24 4,000,000.000	3,946,967.22		3,946,967.22	
	SEL	06/06/24 4,000,000.000	3,959,147.24		3,946,967.22	12,180.02
1 PURCHASES FOR			3,946,967.22	1 SALES FOR		3,946,967.22
				ISSUE AGGREGATE TOTAL		7,906,114.46
CUSIP # U38141W34 GOLDMAN FINANCIAL SQUARE TREAS OBLIGATIONS-A FD# 468 (AMALFTRSY) MASTER#2839100 4.98%	NET		138,698,626.60		138,698,626.60	
	NET		138,401,211.90		138,401,211.90	
178 PURCHASES FOR			138,698,626.60	154 SALES FOR		138,401,211.90
				ISSUE AGGREGATE TOTAL		277,099,838.50