

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

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

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>HRSA-ILA VACATION & HOLIDAY FUND</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>BOARD OF TRUSTEES OF THE HRSA-ILA VACATION & HOLIDAY FUND</u></p> <p><u>1355 INTERNATIONAL TERMINAL BLVD</u> <u>NORFOLK, VA 23505-1458</u></p>	<p>1c Effective date of plan <u>12/01/1982</u></p> <p>2b Employer Identification Number (EIN) <u>54-1220256</u></p> <p>2c Plan Sponsor's telephone number <u>757-457-7090</u></p> <p>2d Business code (see instructions) <u>813000</u></p>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	07/14/2025	JEREMY BRIDGES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	06/30/2025	THOMAS LITTLE
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	2359
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	2359
	6a(2)	2319
	6b	
	6c	
	6d	2319
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	

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:
4Q

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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

A Name of plan HRSA-ILA VACATION & HOLIDAY FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF THE HRSA-ILA VACATION & HOLIDAY FUND	D Employer Identification Number (EIN) 54-1220256	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

HRSA-ILA FRINGE BENEFIT ESCROW FUND

54-1218271

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	RELATED PARTY	120441	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)

BASYS, LLC

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?
16 49	NONE	43973	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)

TOWNE INSURANCE

31-1774380

(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 checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" 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)

CALIBRE CPA GROUP PLLC

47-0900880

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	21820	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)

DIVARIS

54-1358030

(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 99	NONE	20593	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)

WOODS ROGERS VANDEVENTER BLACK PLC

54-1294386

(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	7619	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)

WELLS FARGO BANK NA

41-6257133

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 16	NONE	5193	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024	
A Name of plan HRSA-ILA VACATION & HOLIDAY FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF THE HRSA-ILA VACATION & HOLIDAY FUND	D Employer Identification Number (EIN) 54-1220256

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	89890	94535
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)	8610	8610
(3) Other	1b(3)	7692	280
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	145454	134063
f Total assets (add all amounts in lines 1a through 1e)	1f	251646	237488
Liabilities			
g Benefit claims payable	1g	24557372	25995297
h Operating payables	1h	127	127
i Acquisition indebtedness	1i		
j Other liabilities	1j	165098	155158
k Total liabilities (add all amounts in lines 1g through 1j)	1k	24722597	26150582
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	-24470951	-25913094

Part II Income and Expense Statement

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

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

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		487
d Total income. Add all income amounts in column (b) and enter total	2d		487

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	26153263	
(2) To insurance carriers for the provision of benefits.....	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		26153263
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)	166293	
(2) Contract administrator fees.....	2i(2)		
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)	21820	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	5193	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	8932	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	168878	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		371116
j Total expenses. Add all expense amounts in column (b) and enter total	2j		26524379

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-26523892
l Transfers of assets:			
(1) To this plan	2l(1)		25081749
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: CALIBRE CPA GROUP, PLLC

(2) EIN: 47-0900880

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		3000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

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

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

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

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



**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

FINANCIAL STATEMENTS

SEPTEMBER 30, 2024





**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

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INDEPENDENT AUDITOR'S REPORT

The Board of Trustees
Hampton Roads Shipping Association -
International Longshoremen's Association
Vacation and Holiday Fund

Opinion

We have audited the accompanying financial statements of the Hampton Roads Shipping Association - International Longshoremen's Association Vacation and Holiday Fund (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 financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of September 30, 2024 and 2023, and the changes in its net assets available for benefits and changes in its benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's 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 we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Substantial Doubt About the Entity's Ability to Continue as a Going Concern

The accompanying financial statements have been prepared assuming that the Plan will continue as a going concern. As discussed in Note 8 to the financial statements, the Plan may not be able to fund all future benefit expenses for the year ended September 30, 2025, which raises substantial doubt about its ability to continue as a going concern as of September 30, 2024. Management's plans in regard to these matters are also described in Note 8. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to this matter.





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 for one year after the date that the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.



Auditor's Responsibilities for the Audit of the Financial Statements (continued)

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the 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.

Supplemental Schedule Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) is presented for purposes of additional analysis and is not a required part of the financial statements but is 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 schedule, we evaluated whether the supplemental schedule, including its form and content, is 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 schedule is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content is presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Calibre CPA Group, PLLC

Bethesda, MD
January 23, 2025



**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS AND
OF BENEFIT OBLIGATIONS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

	2024	2023
Assets		
Receivables		
Due from participants and other, net of allowance for expected credit loss of \$2,870 in 2024 and 2023	\$ <u>8,610</u>	\$ <u>8,610</u>
Other assets		
Cash and cash equivalents	94,535	89,890
Prepaid expenses	280	7,692
Operating lease right-of-use asset	<u>134,063</u>	<u>145,454</u>
Total other assets	<u>228,878</u>	<u>243,036</u>
Total assets	<u>237,488</u>	<u>251,646</u>
Liabilities		
Due to related fund	20,023	19,305
Accounts payable and accrued expenses	127	127
Operating lease liability	<u>135,135</u>	<u>145,793</u>
Total liabilities	<u>155,285</u>	<u>165,225</u>
Net assets available for benefits	82,203	86,421
Benefit obligations		
Benefits currently payable to participants	<u>25,995,297</u>	<u>24,557,372</u>
Deficit of net assets available for benefits over benefit obligations	<u>\$ (25,913,094)</u>	<u>\$ (24,470,951)</u>

See accompanying notes to financial statements.



**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS AND
OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

	2024	2023
Additions to net assets attributed to		
Other income	\$ 487	\$ 295
Total additions	487	295
Deductions from net assets attributed to		
Benefits		
Benefits paid	22,961,628	22,836,462
Payroll taxes on benefits	1,753,710	1,750,807
Administrative expenses	371,116	390,282
Total deductions	25,086,454	24,977,551
Transfers from HRSA-ILA Fringe Benefit Escrow Fund	25,081,749	24,967,748
Net change in net assets available for benefits	(4,218)	(9,508)
Net change in benefit obligations		
Change in benefits payable	(1,437,925)	(256,624)
Change in deficiency of net assets available for benefits over benefit obligations	(1,442,143)	(266,132)
Deficit of net assets available for benefits over benefit obligations		
Beginning of year	(24,470,951)	(24,204,819)
End of year	\$ (25,913,094)	\$ (24,470,951)

See accompanying notes to financial statements.



**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following description of the Hampton Roads Shipping Association - International Longshoremen's Association Vacation and Holiday Fund (the Plan) provides only general information. Participants should refer to the Plan Document for a more complete description of the Plan's provisions.

The Plan was formed under a collective bargaining agreement between the Hampton Roads Shipping Association (HRSA) and the International Longshoremen's Association (ILA) (collectively, HRSA-ILA) in order to receive and administer employer contributions necessary to fund vacation and holiday benefits to all port employees who meet certain eligibility requirements. Participants are eligible to receive benefits under the Plan by working or receiving credit for a minimum of 700 hours during the year of eligibility. Based on the number of credit hours accumulated and past years of service, participants may earn up to six weeks of vacation as well as the holiday compensation. Participants are paid annually, their hours are assessed for eligibility at the end of the contract year and benefits are paid in the next. Participants can elect to contribute all or part of their payments to the HRSA-ILA Annuity and Savings Plan on a voluntary pretax basis, subject to certain Internal Revenue Service (IRS) limitations. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Benefit payments are based upon the hours participants have worked for the contract year.

As funds in excess of those currently available in the Plan are needed to pay benefits, monies may be transferred from the HRSA-ILA Fringe Benefit Escrow Fund. Participants do not contribute to the Plan.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting. Under this basis, revenue is recognized when earned and expenses are recognized when incurred, except for the payment of benefits.



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash and Cash Equivalents

Cash and cash equivalents consist of amounts in checking, savings, and money market accounts.

Lease Policy

In its statements of net assets available for benefits and of benefit obligations, the Plan records a right-of-use asset and lease liability, initially measured at the present value of total lease payments using a risk-free rate that approximates the remaining term of the lease. The Plan considers the likelihood of exercising renewal or termination clauses (if any) in measuring its right-of-use assets and lease liabilities. A single lease cost calculated so that the cost of the lease is allocated over the lease term on straight-line basis. Short-term leases (those with an initial term of twelve months or less and no purchase option) are expensed over their terms, with no corresponding right-of-use asset or lease liability recorded. The Plan does not separate non-lease components (if any) from lease components in determining the lease payments for leases of office equipment.

Benefit Obligations

Benefit obligations as of September 30, 2024 and 2023 represent vacation and holiday amounts which had been earned by participants during the years ended September 30, 2024 and 2023, respectively, but had not been paid as of that date.

Contributions

No contributions were made by or on behalf of Plan participants during the years ended September 30, 2024 and 2023.

Payment of Benefits

Benefits are recorded as a deduction from net assets when paid.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and benefit obligations and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

New Accounting Pronouncement Adopted

During the year ended September 30, 2024, the Plan adopted the provisions of Accounting Standards Update (ASU) 2016-13, *Financial Instruments – Credit Losses* (Topic 326). This ASU replaced the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss (CECL) methodology. The ASU requires nonprofit entities to immediately recognize the estimated expected credit losses over the life of a financial instrument. The estimate of expected credit losses considers not only historical information, but also current and future economic conditions and events.

The Plan adopted the ASU effective October 1, 2023. The impact of the adoption was not considered material to the financial statements and primarily resulted in additional disclosures.

NOTE 3. PARTIES-IN-INTEREST AND LEASE COMMITMENTS

The Plan is one of several funds established under collective bargaining agreements between the HRSA and the ILA, which share common trustees, administrative services, and office space. Administrative costs incurred for the benefit of all funds are paid by the HRSA-ILA Fringe Benefit Escrow Fund and allocated to the other funds. The Plan's share of such administrative costs was \$318,409 and \$346,144 for the years ended September 30, 2024 and 2023, respectively. The Plan owed \$20,023 and \$19,305 to the HRSA-ILA Fringe Benefit Escrow Fund at September 30, 2024 and 2023, respectively. Such amounts were reimbursed in the subsequent period.

The related HRSA-ILA funds previously had entered into a collective operating lease agreement with the HRSA-ILA Pension Plan for the use of administrative space due to expire May 31, 2022. During the year ended September 30, 2022, the related HRSA-ILA funds entered into a new five-year lease effective June 1, 2022, and expiring May 31, 2027. The lease also provides an option for an additional five-year term thereafter, for which is reasonably certain to be executed. The base rent is increased annually by an amount equal to the lesser of 3% or the percentage increase in the Consumer Price Index.

The Plan recognized a right-of-use asset and a related lease liability equal to the net present value of the expected future minimum base payments, discounted at 3.67%. The discount rate is based on the risk-free discount rate at the transition date, October 1, 2022, for a period of ten years.



NOTE 3. PARTIES-IN-INTEREST AND LEASE COMMITMENTS (CONTINUED)

The maturity of the lease liability under the Plan's operating lease as of September 30, 2024 is as follows:

Year Ending September 30,	
2025	\$ 20,249
2026	20,249
2027	20,249
2028	20,249
2029	20,249
Thereafter	<u>53,997</u>
Undiscounted future cash flows	155,242
Less: effects of discounting at the rate of 3.67%	<u>(20,107)</u>
	<u>\$ 135,135</u>

Lease expense totaled \$20,593 and \$19,626 for the years ended September 30, 2024 and 2023, respectively.

The Plan also pays certain administrative, investment and professional fees directly to various service providers. These transactions qualify as party-in-interest transactions, which are exempt from the prohibited transaction rules of ERISA.

NOTE 4. PLAN TERMINATION

The trust established under the Plan shall terminate upon fulfillment of the obligations of the employers under the collective bargaining agreements. In the event the employers' obligations were terminated, the trustees will continue to perform all of the provisions of the Plan until final disbursements have been completed and all the obligations under the trust have been fulfilled. Any remaining Plan assets will be distributed to another HRSA-ILA fund. Termination shall not permit any part of the Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of participants.

NOTE 5. TAX STATUS

The Plan is funded using a trust which is tax exempt under Section 501(c)(9) of the Internal Revenue Code as determined in a letter received from the IRS dated July 18, 1986. Although the Plan has been amended since receiving the determination letter, there is no requirement to request an updated determination letter after a plan amendment if the operations of the Plan are consistent with those disclosed in the original application for exemption. The Plan administrator and the Plan's tax counsel believe that the operation of the Plan is consistent with the operations disclosed in the original application for exemption.



NOTE 5. TAX STATUS (CONTINUED)

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the organization has taken an uncertain tax position that more likely than not would not be sustained upon examination by the IRS and Department of Labor. Plan management has analyzed the tax positions taken by the Plan, and has concluded that as of September 30, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements.

The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Plan management believes that the Plan's income tax returns for the years ended September 30, 2021 through 2023 remain subject to examination, based on the normal statutory periods subject to audit, notwithstanding any events or circumstances that may exist which could expand the open period.

NOTE 6. TRANSFERS FROM HRSA-ILA FRINGE BENEFIT ESCROW FUND

The HRSA-ILA Fringe Benefit Escrow Fund was formed under the same collective bargaining agreement (the Collective Bargaining Agreement) between HRSA and ILA for the purpose of receiving and administering employer contributions necessary to fund employee fringe benefit programs required in the Collective Bargaining Agreement including the Plan.

During the years ended September 30, 2024 and 2023, the HRSA-ILA Fringe Benefit Escrow Fund, by authorization of the Board of Trustees, transferred \$25,081,749 and \$24,967,748, respectively, to the Plan. The Plan utilized these transfers to pay benefits and administrative expenses of the Plan. The Board of Trustees has authorized additional transfers as needed to cover benefit payments due. The HRSA-ILA Fringe Benefit Escrow Fund is the only source of funding for the Plan.

NOTE 7. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the accompanying financial statements to the Form 5500 at September 30, 2024 and 2023:

	2024	2023
Net assets available for benefits per the financial statements	\$ 82,203	\$ 86,421
Less: benefit obligations currently payable	<u>(25,995,297)</u>	<u>(24,557,372)</u>
Net assets available for benefits per the Form 5500	<u>\$ (25,913,094)</u>	<u>\$ (24,470,951)</u>



NOTE 7. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (CONTINUED)

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

Benefits paid per the financial statements	
Benefit paid	\$ 22,961,628
Payroll taxes on benefits	1,753,710
Add: benefits currently payable at end of year	25,995,297
Less: benefits currently payable at beginning of year	<u>(24,557,372)</u>
Benefits paid per the Form 5500	<u>\$ 26,153,263</u>

NOTE 8. GOING CONCERN

The Plan, as of September 30, 2024, has a \$25,913,093 deficit of net assets available for benefits over benefit obligations and is dependent on transfers from the HRSA-ILA Fringe Benefit Escrow Fund to fund benefit expenses. The HRSA-ILA Fringe Benefit Escrow Fund, with current contribution rates, may not have the assets available to fund all of the future benefit expenses for the Plan for the year ended September 30, 2025.

This factor creates an uncertainty about the Fund's ability to continue as a going concern. Management of the Plan has decided to request additional funding for the year ending September 30, 2025, in order to maintain the Plan as a going concern.

Management requested \$9,342,539 from the Carrier-ILA Container Royalty Fund No. 5 (CR-5), on behalf of the HRSA-ILA Fringe Benefit Escrow Fund, to help fund benefits for the Plan for the year ended September 30, 2025.

NOTE 9. SUBSEQUENT EVENTS

Subsequent events have been evaluated through January 23, 2025, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.



SUPPLEMENTAL INFORMATION





**HAMPTON ROADS SHIPPING ASSOCIATION -
INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
VACATION AND HOLIDAY FUND**

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

SEPTEMBER 30, 2024

Form 5500, Part IV, Schedule H, Line 4i

EIN: 54-1220256
Plan number: 501

<u>Identity of issuer, borrower or similar party</u>	<u>Description</u>	<u>Cost</u>	<u>Current Value</u>
Cash and cash equivalents			
* Wells Fargo Bank, N.A.	Non-interest bearing cash	<u>\$ 94,535</u>	<u>\$ 94,535</u>
	Total cash and cash equivalents	<u>\$ 94,535</u>	<u>\$ 94,535</u>

* Denotes party-in-interest.

Form 5500 Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210 - 0110 1210 - 0089 <hr/> 2023 <hr/> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2023 or fiscal plan year beginning <u>10/01/2023</u> and ending <u>09/30/2024</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is:	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	<input type="checkbox"/>

Part II Basic Plan Information - enter all requested information							
1a Name of plan HRSA-ILA VACATION & HOLIDAY FUND	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">1b Three-digit plan number (PN) ▶</td> <td style="width:40%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">12/01/1982</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan	12/01/1982		
1b Three-digit plan number (PN) ▶	501						
1c Effective date of plan	12/01/1982						
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) BOARD OF TRUSTEES OF THE HRSA-ILA VACATION & HOLIDAY 1355 INTERNATIONAL TERMINAL BLVD NORFOLK VA 23505-1458	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">2b Employer Identification Number (EIN)</td> <td style="width:40%; text-align: center;">54-1220256</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">757-457-7090</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">813000</td> </tr> </table>	2b Employer Identification Number (EIN)	54-1220256	2c Plan Sponsor's telephone number	757-457-7090	2d Business code (see instructions)	813000
2b Employer Identification Number (EIN)	54-1220256						
2c Plan Sponsor's telephone number	757-457-7090						
2d Business code (see instructions)	813000						

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

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

SIGN HERE	<input checked="" type="checkbox"/> <i>Jeremy Bridges</i>	7-14-25	JEREMY BRIDGES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<input checked="" type="checkbox"/> <i>Thomas Little</i>	6-30-25	THOMAS LITTLE
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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v. 230728

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

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

5 Total number of participants at the beginning of the plan year	5	2,359
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	2,359
a(2) Total number of active participants at the end of the plan year	6a(2)	2,319
b Retired or separated participants receiving benefits	6b	
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	2,319
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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:
4Q

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input 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)

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