Form 5500-SF

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed 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-SF.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for: [X] a single-employer plan [ ] a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)

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 Check box if filing under: [ ] Form 5558 [ ] automatic extension [ ] DFVC program
[ ] special extension (enter description)

D If the plan is a collectively-bargained plan, check here ▸ [ ]

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▸ [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan
THE ASTRONAUTS MEMORIAL FOUNDATION DEFINED CONTRIBUTION RETIREMENT PLAN

1b Three-digit plan number (PN) ▸ 001

1c Effective date of plan 05/01/1999

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)
THE ASTRONAUTS MEMORIAL FOUNDATION

THAD ALTMAN

SR 405 BLDG M6--306, SUITE 5000
MAIL CODE AMF
KENNEDY SPACE CENTER, FL 32899-0001

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2b Employer Identification Number (EIN) 59-2637266

2c Sponsor's telephone number 321-378-9810

2d Business code (see instructions) 611000

3a Plan administrator's name and address [ ] Same as Plan Sponsor.

THE ASTRONAUTS MEMORIAL FOUNDATION
LAURA LEWIS

SR 405 BLDG M6--306, SUITE 5000
MAIL CODE AMF
KENNEDY SPACE CENTER, FL 32899-0001

3b Administrator's EIN 59-2637266

3c Administrator's telephone number 321-378-9810

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

Item	Description	Line	Value
5a	Total number of participants at the beginning of the plan year	5a	20
b	Total number of participants at the end of the plan year	5b	23
c(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	5c(1)	20
c(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c(2)	23
d(1)	Total number of active participants at the beginning of the plan year	5d(1)	5
d(2)	Total number of active participants at the end of the plan year	5d(2)	8
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0

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, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.	07/29/2025	LAURA LEWIS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No

b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No

If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year____________________. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1482319	1749636
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	1482319	1749636
8 Income, Expenses, and Transfers for this Plan Year		**(a) Amount**	**(b) Total**
a Contributions received or receivable from: (1) Employers	8a(1)	70272	
(2) Participants	8a(2)	7647	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	214942	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		292861
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	25544	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		25544
i Net income (loss) (subtract line 8h from line 8c)	8i		267317
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2G 2L 2T

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

Part V Compliance Questions

10 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)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c		X	
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below. ☐ Yes ☐ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 ... **11a**

b **PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than $0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation ________________

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ... (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above. ☒ Yes ☐ No

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. ... Month ________ Day ________ Year ________

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b	Enter the minimum required contribution for this plan year ...	**12b**	
c	Enter the amount contributed by the employer to the plan for this plan year ...	**12c**	
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) ...	**12d**	
e	Will the minimum funding amount reported on line 12d be met by the funding deadline? ...	☐ Yes ☐ No ☐ N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ... ☐ Yes ☒ No

a If "Yes," enter the amount of any plan assets that reverted to the employer this year ... **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ... ☐ Yes ☒ No

c 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.)

13c(1) Name of plan(s):	**13c(2)** EIN(s)	**13c(3)** PN(s)

Part VIII IRS Compliance Questions

14a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? ☒ Yes ☐ No

14b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- ☐ Design-based safe harbor method
- ☐ "Prior year" ADP test
- ☐ "Current year" ADP test
- ☐ N/A

15 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/_____ (MM/DD/YYYY) and the Opinion Letter serial number__________.

5500 Reportable Transactions

ASTRONAUTS MEMORIAL FOUNDATION

Summary of 5% Reportable Transactions
Pursuant to Department of Labor Regulation (DOL) 2520.103-(6)(c)
For the Plan Year Ending: 12/31/2024

Beginning Plan Balance (1):	$1,482,318.90
5% of Beginning Balance (applicable for IRS Form 5500, Schedule H filers):	$74,115.95

Schedule below is a record of all non-participant directed transactions pursuant to IRS Form 5500 instructions.

Transactions pursuant to DOL Sec. 2520-103-6(c)(1)(i) and 2520.103-6(d):
A transaction within the plan year, with respect to any plan asset, involving amount in excess of 5% for Schedule H filers of the current value of plan assets.

Description of Asset/Transaction	Date	Purchase Price	Sales Price	Expense Incurred	Cost of Assets	Realized Gain (Loss)	% to Balance

NO NON-PARTICIPANT DIRECTED TRANSACTIONS

Department of Labor regulations require that reportable transactions be determined based on the value of the plan assets as of the beginning of the plan, (unless the Form 5500 is being filed for the initial plan year in which case the value of the plan assets as of the end of the plan year is used). Please note that if your plan converted to TIAA-CREF during the plan year, or TIAA-CREF did not recordkeep all of the plan assets as of the beginning of the plan year, TIAA-CREF is unable to determine the actual value of the plan assets as of the beginning of the plan year. Therefore, the beginning of the year value reflected on this report would not be correct. You should apply the value of the transactions identified on this report to the actual value of the assets as of the beginning of the plan year to determine whether or not they are reportable (i.e., exceed 5% of the actual value of the plan assets as of the beginning of the year).

FILING SUMMARY FOR SCHEDULE A

ASTRONAUTS MEMORIAL FOUNDATION

Activity for the Reporting Period: 01/01/2024 to 12/31/2024

Part I Line 1 : Coverage Information	
Name of Insurance carrier (Enter on Line 1a)	TIAA-CREF
Employer Identification Number (Enter on Line 1b)	13-1624203
National Association of Insurance Commissioners code (Enter on Line 1c)	69345
Contract or identification number (Enter on Line 1d)	330043
Approximate number of persons covered at end of policy or contract year (Enter on Line 1e)	23
Policy or contract year – From (Enter on Line 1f)	01/01/2024
Policy or contract year – To (Enter on Line 1g)	12/31/2024
Part I Line 2 : Insurance fee and commission information	
Total amount of commissions paid (Enter on Line 2)	$0.00
Total amount of fees paid (Enter on Line 2)	$0.00
Part I Line 3 : Persons receiving commissions and fees	
Name and address of the agent, broker, or other person to whom commissions or fees were paid(Enter on Line 3a)	<No Entry Required>
Amount of commissions paid (Enter on Line 3b)	<No Entry Required>
Fees paid – Amount (Enter on Line 3c)	<No Entry Required>
Fees paid – Purpose (Enter on Line 3d)	<No Entry Required>
Fees paid – Organization code (Enter on Line 3e)	<No Entry Required>
Part II Lines 4 and 5 : Investment and Annuity Contract Information	
Current value of plan's interest under this contract in the general account at year end (Enter on Line 4)	$240,075.37
Current value of plan's interest under this contract in separate accounts at year end (Enter on Line 5)	$1,509,560.32
Part II Line 6 : Contracts With Allocated Funds	<No Entry Required>
Part II Line 7 : Contracts With Unallocated Funds	
Type of contract (Enter on Line 7a)	3 - Guaranteed Investment
Balance at the end of the previous year (Enter on Line 7b)	$169,326.97
Contributions deposited during the year (Enter on Line 7c(1))	$1,476.88
Dividends and credits (Enter on Line 7c(2))	$0.00
Interest credited during the year (Enter on Line 7c(3))	$9,261.26
Transferred from separate account (Enter on Line 7c(4))	$159,776.69
Other (Enter on Line 7c(5))	$0.00
Disbursed from fund to pay benefits or purchase annuities during the year (Enter on Line 7e(1))	($9,743.66)
Administration charge made by carrier (Enter on Line 7e(2))	N/A
Transferred to separate account (Enter on Line 7e(3))	($90,022.77)
Other (Enter on Line 7e(4))	$0.00
Balance at the end of the current year (Enter on Line 7f)	$240,075.37
Part III Line 8, 9 and 10 : Welfare Benefit Contract Information	<No Entry Required>
Part IV Line 11 and Line 12 : Provision of Information	Complete only if insurance company failed to provide information to complete Schedule A

FILING SUMMARY FOR SCHEDULE - C

ASTRONAUTS MEMORIAL FOUNDATION

Activity for the Reporting Period: 01/01/2024 to 12/31/2024

Part I, Line 1 : Information on Persons Receiving Only Eligible Indirect Compensation	
(Enter on Line 1 a)	YES
Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation (Enter on Line b)	TIAA 13-1624203

Part I, Line 2 : Information on Other Service Providers Receiving Direct or Indirect Compensation	
Enter name and EIN or address (Enter on Line a) Service Code(s) (Enter on Line b) Relationship to employer, employee organization, or person known to be a party-in-interest (Enter on Line c) Enter direct compensation paid by the plan. If none, enter -0- (Enter on Line d) Did service provider receive indirect compensation? (Enter on Line e) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? (Enter on Line f) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0- (Enter on Line g) Did the service provider give you a formula instead of an amount or estimated amount? (Enter on Line h)	No entry required

Part I, Line 3 : Service Provider Information (Continued)	
Enter service provider name as it appears on line 1 (Enter on Line a) Service code(s) (Enter on Line b) Enter amount of indirect compensation (enter on Line c) Enter name and EIN (address) of source of indirect compensation (Enter on Line d) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation (Enter on Line e)	No entry required

Part I, Line 4 : Service Providers Who Fail or Refuse to Provide Information	
Enter name and EIN or address of service provider (see instructions) (Enter on Line a) Nature of Service Code(s) (Enter on Line b) Describe the information that the service provider failed or refused to provide (Enter on Line c)	No entry required

Part II : Termination Information on Accountants and Enrolled Actuaries	
Name (Enter on Line a) EIN (Enter on Line b) Position (Enter on Line c) Address (Enter on Line d) Telephone No. and Explanation (Enter on Line e) Explanation (Enter in space provided)	To be completed by Plan Sponsor

"For additional guidance on completing Form 5500 Schedule C, refer to the TIAA-CREF Service & Fee Disclosure Guide - Appendix A and B"

FILING SUMMARY FOR SCHEDULE - D

ASTRONAUTS MEMORIAL FOUNDATION

Activity for the Reporting Period: 01/01/2024 to 12/31/2024

Part I : Information on interests in Master Trust Investment Accounts, Common / Collective Trusts, Pooled Separate Accounts, and 103-12 Investment Entities (to be completed by plans and Direct Filing Entities)	
Name of MTIA, CCT, PSA or 103-12 IE (Enter on Line a)	TIAA Real Estate
Name of sponsor of entity listed in (a) (Enter on Line b)	TIAA-CREF
Employer Identification Number-Plan/Entity Number (Enter on Line c)	13-1624203-004
Entity Code (Enter on Line d)	P
Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (Enter on Line e)	$67,339.50

Part II : Information on Participant Plans (to be completed by Direct Filing Entities)	**Do not make an entry in Part II**

FILING SUMMARY FOR SCHEDULE H

ASTRONAUTS MEMORIAL FOUNDATION

Activity for the Reporting Period: 01/01/2024 to 12/31/2024

Part I: Asset and Liability Statement : Assets	
Opening Loan Fund Total (Enter Amount on Line 1c(8) Column (a))	$0.00
Closing Loan Fund Total (Enter Amount on Line 1c(8) Column(b))	$0.00
Opening Common/Collective Trust Total (Enter Amount on Line 1c(9) Column (a))	$0.00
Closing Common/Collective Trust Total (Enter Amount on Line 1c(9) Column (b))	$0.00
Opening Pooled Separate Account Total (Enter Amount on Line 1c(10) Column (a))	$63,403.95
Closing Pooled Separate Account Total (Enter Amount on Line 1c(10) Column (b))	$67,339.50
Opening Master Trust Investment Account Total (Enter Amount on Line 1c(11) Column (a))	$0.00
Closing Master Trust Investment Account Total (Enter Amount on Line 1c(11) Column (b))	$0.00
Opening 103-12 Investment Entity Total (Enter Amount on Line 1c(12) Column (a))	$0.00
Closing 103-12 Investment Entity Total (Enter Amount on Line 1c(12) Column (b))	$0.00
Opening Registered Investment Companies Total (Enter Amount on Line 1c(13) Column (a))	$1,249,587.98
Closing Registered Investment Companies Total (Enter Amount on Line 1c(13) Column (b))	$1,442,220.82
Opening Insurance Company General Account (Unallocated contracts) (Enter Amount on Line 1c(14) Column (a))	$169,326.97
Closing Insurance Company General Account (Unallocated contracts) (Enter Amount on Line 1c(14) Column (b))	$240,075.37
Opening Self Directed Accounts Total (Enter Amount on Line 1c(15) Column (a))	$0.00
Closing Self Directed Accounts Total (Enter Amount on Line 1c(15) Column (b))	$0.00

Part II: Income and Expense Statement: Income	
Plan Contributions – Employer (Enter Amount on Line 2a(1)(A))	$70,272.03
Plan Contributions – Employee (Enter Amount on Line 2a(1)(B))	$7,646.88
Plan Contributions – Others (Enter Amount on Line 2a(1)(C))	$0.00
Participant Loan Fund earnings (Enter Amount on Line 2b(1)(E))	$0.00
Interest: Other (Enter Amount on Line 2b(1)(F))	$9,261.26
Plan Registered Investment Companies dividends (Enter Amount on Line 2b(2)(C))	$0.00
Plan Common/Collective Trust earnings (Enter Amount on Line 2b(6))	$0.00
Plan Pooled Separate Accounts earnings (Enter Amount on Line 2b(7))	($2,474.73)
Plan Master Trust Investment Account earnings (Enter Amount on Line 2b(8))	$0.00
Plan 103-12 Investment Entity earnings (Enter Amount on Line 2b(9))	$0.00
Plan Registered Investment Companies earnings (Enter Amount on Line 2b(10))	$208,155.01
Other Income (Enter Amount on Line (2c))	$0.00

Part II: Income and Expense Statement: Expenses	
Plan Expenses – Directly to participants or beneficiaries (Enter Amount on Line 2e(1))	($25,543.66)
Plan Expenses – To insurance carriers for the provision of benefits (Enter Amount on Line 2e(2))	$0.00
Certain deemed distributions of participant loans (Enter Amount on Line 2g)	$0.00
Administrative expenses - Contract administrator fees (Enter Amount on Line 2i(2))	$0.00
Administrative expenses - Investment advisory and management fees (Enter Amount on line 2i(3)	$0.00
Administrative expenses - Other (Enter Amount on Line 2i(4))	$0.00
Transfers To the Plan (Enter Amount on Line 2l(1))	$0.00
Transfers From the Plan (Enter Amount on Line 2l(2))	$0.00

Participant Count

ASTRONAUTS MEMORIAL FOUNDATION

Activity for the Reporting Period: 01/01/2024 to 12/31/2024

5	Total Number of participants at beginning of Plan Year	23
6a(1)	Active participants at the beginning of the plan year	8
6a(2)	Active participants at the end of the plan year	9
6b	Retired or separated participants receiving benefits	0
6c	Other retired or separated participants entitled to future benefits	14
6d	Subtotal (6a(2), 6b and 6c)	23
6e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	0
6f	Total (6d and 6e)	23
6g(1)	Number of participants with accounts balances at beginning of Plan year	23
6g(2)	Number of participants with accounts balances at end of Plan year	23
6h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	0