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

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 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
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/27/1955

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 SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS
WELFARE FUND

1171 COMMERCE DRIVE, UNIT 1
WEST CHICAGO, IL 60185

2b Employer Identification Number (EIN)
36-6158494

2c Plan Sponsor's telephone number
630-293-5218

2d Business code (see instructions)
484120

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.	10/07/2025	DOMINIC ROMANAZZI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/08/2025	WILLIAM E. BRACH
	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 [X] 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**	4417
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)**	3508
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	3146
b	Retired or separated participants receiving benefits	**6b**	954
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	4100
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)**	
g(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**	428

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

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

4A 4B 4D 4E 4F

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1) [ ]	Insurance	**(1)** [X]	Insurance
(2) [ ]	Code section 412(e)(3) insurance contracts	**(2)** [ ]	Code section 412(e)(3) insurance contracts
(3) [X]	Trust	**(3)** [X]	Trust
(4) [ ]	General assets of the sponsor	**(4)** [ ]	General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TRUSTEES OF SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS

D Employer Identification Number (EIN)
36-6158494

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
ELCO MUTUAL LIFE AND ANNUITY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
36-2123818	84174	L033000	2953	09/01/2023	08/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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** [X] Other (specify) ▶ AD&D

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	399085
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] 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

2024

This Form is Open to Public Inspection

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

A Name of plan
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TRUSTEES OF SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS

D Employer Identification Number (EIN)
36-6158494

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
SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-0734860	71420	H2001	1390	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	3641441
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TRUSTEES OF SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS

D Employer Identification Number (EIN)
36-6158494

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).. . . . . [X] 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

BAIRD ADVISORS

39-6037917

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

U.S. BANCORP ASSET MANAGEMENT, INC.

41-2003732

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

U.S. BANCORP FUND SERVICES, LLC

39-1939072

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

INTERCONTINENTAL REAL ESTATE CORP.

04-2895544

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

BRIGADE CAPITAL MANAGEMENT, LP

26-0240191

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

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

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

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

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

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

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

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

BLUE CROSS BLUE SHIELD OF IL

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 73	NONE	1774050	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

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

DESERT SHORE CAPITAL PARTNERS LLC

84-2853707

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	348416	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(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	181046	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

SUE SELIMOS

36-6158494

(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	173061	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INETICO, LLC

36-4869660

(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	150018	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PRUDENTIAL TRUST CO.

81-6695909

(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 21 28 52 72	NONE	143945	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

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)

JULIE SZCZEPANIK

36-6158494

(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	123832	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

TERESA SELIG

36-6158494

(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	117989	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CJBS, LLC

36-3524803

(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	103020	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

ANDREA BICKNELL

36-6158494

(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	101609	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ARNOLD AND KADJAN LLP

36-2498571

(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	96000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SANDRA AURIEMMA

36-6158494

(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	90656	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

DIANNA FIEDLER

36-6158494

(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	90405	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BRIDGEWAY BENEFIT TECHNOLOGIES, INC

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?
15	NONE	88889	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CAROLINA SAENZ

36-6158494

(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	87632	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

DELTA DENTAL OF ILLINOIS

36-2612058

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	84709	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MARTHA MANJARREZ

36-6158494

(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	83989	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GUADALUPE MARTINEZ

36-6158494

(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	73054	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

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	71281	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

FOSTER & FOSTER, INC.

59-1921114

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16	NONE	70470	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PAMELA KAUTZ

36-6158494

(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	70209	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

KROGER PRESCRIPTIONS PLANS, INC.

20-5927634

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	66657	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PREFERRED NETWORK ACCESS, INC.

36-4018433

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	66441	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

JOSE COLIN

36-6158494

(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 30	EMPLOYEE	64905	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

INCOME RESEARCH & MANAGEMENT

04-2955404

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28	NONE	57496	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TELADOC HEALTH, INC.

04-3705970

(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 55	NONE	56280	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JESSICA VABALES

36-6158494

(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	55649	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

ABSOLUTE SOLUTIONS LLC

27-3584158

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	41756	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EYEMED VISION CARE

31-1656473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	38111	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MICHELLE NGUYEN

36-6158494

(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	37574	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

LASALLE CONSULTING PARTNERS, INC.

36-4030449

(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	37285	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASHLEY MUELLER

36-6158494

(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	36526	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LISA SOWINSKI

36-6158494

(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	31848	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SEGAL MARCO ADVISORS

13-2646110

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

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

HEATHER MONTALBANO

36-6158494

(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	29432	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ZELIS RED-CARD SYSTEMS, LLC

84-3069529

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	26111	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

GREEN LIGHT COST MANAGEMENT, LLC

45-5248276

(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	19326	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TCMS

32-0112720

(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	14512	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DATAMATION IMAGING SERVICES CORP.

36-4303011

(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 49	NONE	12825	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

SEBERT LANDSCAPING

36-4359043

(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	12281	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

U.S. BANK NATIONAL ASSOCIATION

31-0841368

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28	NONE	9375	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CONTEXT 4 HEALTHCARE

27-0386030

(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	5788	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

TOTAL FIRE & SAFTEY, INC.

43-1866691

(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	5460	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BOND BROTHERS & COMPANY

36-2433269

(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	5310	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(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 [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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 D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
TRUSTEES OF SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS

D Employer Identification Number (EIN)
36-6158494

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: PGIM CORE CONSERVATIVE BOND FUND

b Name of sponsor of entity listed in (a): PRUDENTIAL TRUST CO.

c EIN-PN 81-6695909-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 26284995

a Name of MTIA, CCT, PSA, or 103-12 IE: PGIM QS S&P 500 INDEX FUND

b Name of sponsor of entity listed in (a): PRUDENTIAL TRUST CO.

c EIN-PN 86-1791757-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 25611469

a Name of MTIA, CCT, PSA, or 103-12 IE: IR&M SHORT FUND LLC

b Name of sponsor of entity listed in (a): INCOME RESEARCH & MANAGEMENT

c EIN-PN 27-4824046-001 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 23569068

a Name of MTIA, CCT, PSA, or 103-12 IE: JENNISON US SMALL CAP EQUITY

b Name of sponsor of entity listed in (a): PRUDENTIAL TRUST CO.

c EIN-PN 86-1820589-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3340756

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

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a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TRUSTEES OF SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS

D Employer Identification Number (EIN)
36-6158494

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.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	7212215	7259045
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	6266085	5433981
(2) Participant contributions	1b(2)	99982	75617
(3) Other	1b(3)	1462906	1856248
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	282867	414006
(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)	31886092	32745648
(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)	52689501	55237220
(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)	22479716	23569068
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	19121914	19476249
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	28312	28264
f Total assets (add all amounts in lines 1a through 1e)	1f	141529590	146095346
Liabilities			
g Benefit claims payable	1g	8612596	9023736
h Operating payables	1h	210206	220137
i Acquisition indebtedness	1i		
j Other liabilities	1j	114147	70541
k Total liabilities (add all amounts in lines 1g through1j)	1k	8936949	9314414
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	132592641	136780932

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)	65027502	
(B) Participants	2a(1)(B)	4129453	
(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)		69156955
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	152	
(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)		152
(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)	779500	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		779500
(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)	1017729	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		1017729

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		6191403
(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)		1145993
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-414099
c Other income	2c		3883151
d Total income. Add all **income** amounts in column (b) and enter total	2d		81760784
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	67945833	
(2) To insurance carriers for the provision of benefits	2e(2)	4005381	
(3) Other	2e(3)	2671164	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		74622378
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)	1299975	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	313265	
(4) IQPA audit fees	2i(4)	59700	
(5) Investment advisory and investment management fees	2i(5)	399621	
(6) Bank or trust company trustee/custodial fees	2i(6)	182	
(7) Actuarial fees	2i(7)	70470	
(8) Legal fees	2i(8)	167281	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	24730	
(11) Other expenses	2i(11)	614891	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		2950115
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		77572493
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		4188291
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] 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)** [X] 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
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.)	4a		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.)	4b		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.)	4c		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.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		4000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		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?	4g	X		14195439
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?	4h		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.)	4i	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.)	4j	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?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		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.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] 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 _____.

Suburban Teamsters of Northern Illinois
Welfare Fund

Financial Statements

December 31, 2024

Suburban Teamsters of Northern Illinois
Welfare Fund

Financial Statements with Supplementary Information

December 31, 2024 and 2023

Contents

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

Report of Independent Auditors

To the Participants and Trustees of
Suburban Teamsters of
Northern Illinois Welfare Fund

Opinion

We have audited the financial statements of Suburban Teamsters of Northern Illinois Welfare 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 December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of Suburban Teamsters of Northern Illinois Welfare Fund as of December 31, 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 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.

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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

August 14, 2025

Suburban Teamsters of Northern Illinois
Welfare Fund

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
Assets		
Cash	$ 7,483,564	$ 7,305,884
Receivables		
Employer contributions - net	5,433,981	6,266,085
Participant and retiree contributions	75,617	99,982
Prescription drug rebates and subsidies	1,813,423	1,140,536
Accrued interest and dividends	714	841
Total receivables	7,323,735	7,507,444
Investments - at fair value		
Pooled investment funds	56,314,716	54,365,808
Common and collective trusts	55,237,220	52,689,501
Mutual fund	19,476,249	19,121,914
Money market fund	189,487	189,198
Total investments	131,217,672	126,366,421
Property and equipment - net	28,264	28,312
Prepaid expenses	42,111	321,529
Total assets	146,095,346	141,529,590
Liabilities and Net Assets		
Liabilities		
Accounts payable	220,137	210,206
Due to related organization	70,541	114,147
Total liabilities	290,678	324,353
Net assets available for benefits	$ 145,804,668	$ 141,205,237

See accompanying notes to financial statements.

Suburban Teamsters of Northern Illinois
Welfare Fund

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
Additions		
Investment income		
Net appreciation in fair value of investments	$ 7,941,026	$ 7,792,698
Interest and dividends	779,652	654,821
	8,720,678	8,447,519
Less investment expenses	(399,621)	(230,347)
Investment income - net	8,321,057	8,217,172
Employer contributions	65,027,502	68,113,114
Participant and retiree contributions	4,129,453	3,858,918
Prescription drug rebates and subsidies	3,882,715	2,319,703
Other income	436	167
Total additions	81,361,163	82,509,074
Deductions		
Cost of benefits		
Self-insured benefits	67,534,693	68,885,279
Insurance premiums	4,005,381	3,772,165
PPO and administrative fees	2,521,146	2,242,144
Hospital utilization review	94,668	97,587
Diabetes management fees	55,350	76,980
Total cost of benefits	74,211,238	75,074,155
Fees mandated by ACA	32,522	30,021
Administrative expenses	2,517,972	2,532,429
Total deductions	76,761,732	77,636,605
Net increase	4,599,431	4,872,469
Net assets available for benefits		
Beginning of year	141,205,237	136,332,768
End of year	$ 145,804,668	$ 141,205,237

See accompanying notes to financial statements.

Suburban Teamsters of Northern Illinois Welfare Fund

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
Amounts currently payable		
Claims payable and claims incurred but not reported	$ 6,960,000	$ 7,564,000
Blue Cross Blue Shield claims and fees payable	2,052,836	1,024,496
Total amounts currently payable	9,012,836	8,588,496
Other obligations for current benefit coverage, at estimated amounts		
Accumulated eligibility credits	35,430,000	33,691,000
Postretirement benefit obligations, net of amounts currently payable		
Retired participants and beneficiaries	26,928,000	18,771,000
Other participants fully eligible for benefits	37,409,000	51,559,000
Other participants not yet fully eligible for benefits	38,561,000	60,403,000
Total postretirement benefit obligations	102,898,000	130,733,000
Total benefit obligations	$ 147,340,836	$ 173,012,496

See accompanying notes to financial statements.

Suburban Teamsters of Northern Illinois Welfare Fund

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
Amounts currently payable		
Balance at beginning of year	$ 8,588,496	$ 11,715,834
Increase (decrease) during the year attributable to changes in		
Claims payable and claims incurred but not reported	(604,000)	(2,654,000)
Blue Cross Blue Shield claims and fees payable	1,028,340	(473,338)
Balance at end of year	9,012,836	8,588,496
Other obligations for current benefit coverage, at estimated amounts		
Balance at beginning of year	33,691,000	36,492,000
Increase (decrease) during the year attributable to changes in		
Accumulated eligibility credits	1,739,000	(2,801,000)
Balance at end of year	35,430,000	33,691,000
Postretirement benefit obligations		
Balance at beginning of year	130,733,000	125,493,000
Increase (decrease) during the year attributable to		
Changes in actuarial assumptions	(7,938,000)	625,000
Changes to projected claims costs	(8,389,000)	4,508,000
Benefits accumulated during the year	6,132,000	5,409,000
Passage of time	6,219,000	6,012,000
Experience (gain)	(17,520,000)	(5,260,000)
Benefits paid during the year	(6,339,000)	(6,054,000)
Balance at end of year	102,898,000	130,733,000
Total benefit obligations	$ 147,340,836	$ 173,012,496

See accompanying notes to financial statements.

Suburban Teamsters of Northern Illinois
Welfare Fund

Notes to Financial Statements

December 31, 2024 and 2023

Note 1. Summary of Significant Accounting Policies

Method of Accounting - The accompanying financial statements of Suburban Teamsters of Northern Illinois Welfare Fund (the Plan) have been prepared using the accrual basis of accounting.

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 the investments are reflected on a trade-date basis.

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

Contributions Receivable - Employer contributions due and not paid prior to year end are recorded as contributions receivable. Promissory notes due from employers for uncollected deficiencies, including those established through payroll compliance audits, are recorded net of amounts deemed uncollectible. Allowances for doubtful accounts of $870,454 and $1,083,391 at December 31, 2024 and 2023, respectively, are based on the likelihood of future collections, as determined by a review of historical losses and the aging of receivables, adjusted for management's assessment of current conditions, and reasonable and supportable forecasts regarding future events.

Property and Equipment - Property and equipment consist of office equipment, which is 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 is computed by the straight-line method over estimated useful lives of five years.

Depreciation expense was $8,516 and $18,061 for the years ended December 31, 2024 and 2023, respectively. Accumulated depreciation was $550,944 and $649,367 as of December 31, 2024 and 2023, respectively.

Prepaid Expenses - Prepaid expenses primarily represent insurance premiums paid in advance of the corresponding benefit month.

Note 1. Summary of Significant Accounting Policies (continued)

Benefit Obligations - Benefit obligations are determined by the Plan's actuary using accepted actuarial principles, based on paid and incurred claim cost studies, Plan benefits and other data as considered necessary. Health claims incurred by retired participants but not reported at year end are included in the postretirement benefit obligations. Accumulated eligibility credits represent an estimate of claims which will be due the following year for participants who had been credited with sufficient hours prior to December 31 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 weeks or 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 2 within a jurisdiction primarily located in northern Illinois.

Benefits - All benefits for active participants except for life insurance and accidental death and dismemberment (AD&D) benefits are paid on a self-funded basis. Life insurance and AD&D benefits are provided by Employees Life Company under a non experience-rated insurance contract. The Plan maintains a Preferred Provider Option (PPO) network with Blue Cross Blue Shield of Illinois. The Plan maintains agreements with Sav-Rx and Kroger Prescription Plans to provide prescription drug benefits, Delta Dental of Illinois for dental benefits and EyeMed Vision Care for vision benefits.

Prescription Drug Rebates - The Plan utilizes a pharmacy benefit manager (PBM) who periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds from the PBM due at year end have been reported as a receivable.

Health Reimbursement Accounts - Included in net assets available for benefits as of December 31, 2024 and and 2023 are amounts available to reimburse participants for qualifying medical expenses totaling approximately $1,388,000 and $1,484,000 respectively. At December 31, 2024 and and 2023, a total of $10,900 and $24,100 respectively, in HRA reimbursements had been approved but not yet paid.

Leases - Arrangements for shared office space with related parties are described in Note 6. 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 generally accepted accounting principles.

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

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 August 14, 2025, which is the date the financial statements were available to be issued.

Note 2. Description of the Plan

The Plan was established during 1951 as a result of various collective bargaining agreements. The purpose of the Plan is to provide hospital, surgical, life insurance and other health and welfare benefits for eligible participants and their beneficiaries. The Plan is a multiemployer welfare plan, subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

A participant becomes eligible to participate in the weekly class of the Plan on the first day of the third calendar month after the month in which the fourth week falls (within any period of 26 consecutive weeks) for which the employer has paid to the Plan contributions required by the terms of either a collective bargaining or other agreement. The Plan provides weekly employees a 32-week look-back period which extends eligibility based on a rolling 12-month work period.

A participant becomes eligible to participate in the hourly class of the Plan on the first day of the second calendar month after a total of 350 credited hours in a two or three month period or a period of six consecutive months with a total of 500 credited hours. Retiree eligibility is described in Note 11.

Following the date the employer is no longer obligated to make a contribution to the Plan, a participant will be eligible to receive benefits under the Plan through the last day of the last benefit month for which the participant was eligible due to employer contributions and/or weekly self-payments, and will remain eligible for at least two more calendar months but not more than three calendar months. A participant whose eligibility will terminate may request to continue coverage by submitting a written application to the Plan. Such coverage requires self-pay contributions in the amounts and for the periods specified in the Plan document.

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.

The Plan also offers a Health Reimbursement Account (HRA) arrangement. An HRA is an account that the Plan sets up and maintains on behalf of a participant to keep track of contributions, reimbursements and a participant's available balance. Each HRA account is funded exclusively through contributions made on a participant's behalf by an employer that contributes to the Plan under a collective bargaining or participation agreement. The amount of contributions is determined by the Board of Trustees and is subject to change or discontinuance at any time. Participants are not vested in the contributions made on their behalf and their available balance may be used only for certain health care expenses that are not otherwise covered by the Plan, or to make self-payments to maintain eligibility. No earnings are credited to a participant's HRA and unused HRA balances are not subject to forfeiture. The HRA benefit to which a participant is entitled is the benefit that can be provided from the participant's HRA account.

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

Note 3. Priorities upon Termination

It is the intent of the Trustees to continue the Plan in full force and effect; however, 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. Any remaining Plan assets will be distributed in such manner as will in the opinion of the Trustees bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

Note 4. Tax Status

The Internal Revenue Service has advised that the trust established under the Plan was in compliance with the applicable requirements of the Internal Revenue Code. 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. They 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 by the Plan and recognize a tax liability if the Plan has taken an uncertain position 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. 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 5. Fair Value Measurements (continued)

The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following tables set forth, by level within the fair value hierarchy, the Plan's investment assets at fair value as of December 31, 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. In accordance with generally accepted accounting principles, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in the following tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

		Fair Value Measurements at 12/31/24 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual fund	$ 19,476,249	$ 19,476,249	$ -	$ -
Money market fund	189,487	-	189,487	-
	19,665,736	$ 19,476,249	$ 189,487	$ -
Investments measured at net asset value:				
Pooled investment funds	56,314,716			
Common and collective trusts	55,237,220			
Total	$ 131,217,672			

		Fair Value Measurements at 12/31/23 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual fund	$ 19,121,914	$ 19,121,914	$ -	$ -
Money market fund	189,198	-	189,198	-
	19,311,112	$ 19,121,914	$ 189,198	$ -
Investments measured at net asset value:				
Pooled investment funds	54,365,808			
Common and collective trusts	52,689,501			
Total	$ 126,366,421			

Note 5. Fair Value Measurements (continued)

Level 1 Measurements

The fair value of the mutual fund is determined by reference to the fund's underlying assets, which are principally marketable 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.

Level 2 Measurements

The money market fund is valued at cost, which approximates its fair value.

Measurements Using Net Asset Value as a Practical Expedient

Certain investments are valued at the net asset value per share, used as a practical expedient to estimate fair value. The net asset value is based on the fair values of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported net asset value.

The fair value of one pooled investment fund equal to $14,195,439 and $14,981,281 at December 31, 2024 and 2023, respectively, is determined by the fund's manager without further adjustment and is generally equal to or based upon the reported capital account of the underlying investments, which consist primarily of office, multi-family and other real estate properties located in the United States. Complete or partial withdrawals are allowed on a quarterly basis upon 90 business days' prior notice.

The fair values of the remaining pooled investment funds are determined by reference to the funds' underlying assets, which are principally fixed income securities, including, but not limited to, U.S. dollar denominated bonds, secured floating rate loans of non-investment grade companies and other financial instruments which provide exposure to various fixed income characteristics. Complete or partial withdrawals are allowed on the last business day of each month upon 30 business days' prior notice, although in certain cases, the manager may, in its sole discretion, permit withdrawals at other times.

The common and collective trusts are direct filing entities (DFEs) and file a Form 5500 annual report with the U.S. Department of Labor. The Plan is not required to disclose the significant investment strategies of DFE investments. There are no redemption restrictions on these investments and no notice period prior to redemption is required.

Note 6. Related Organizations

The Plan is related to several entities which include a pension plan and three affiliated local unions.

The Plan shares facilities, equipment and staff with the pension plan. Expenses associated with the shared staff and building are initially paid by the pension plan and are reimbursed based on an allocation using estimates of time spent and square footage and totaled $1,030,784 and $926,347 for the years ended December 31, 2024 and 2023, respectively. At December 31, 2024 and 2023, the Plan owed $70,541 and $114,147 respectively, to the pension plan for shared expenses.

Effective January 1, 2024, the Plan entered into a lease agreement with the pension plan for office space which expires on December 31, 2028. The Plan's rent is based on the total square footage occupied by the Plan at a rate of $16 per square foot. Monthly rent as of January 1, 2024 is $8,295 for the term of the lease. In addition, the Plan is responsible for a pro rata share of real estate taxes and operating expenses, including utilities and maintenance. Rent expense was $99,543 for each of the years ended December 31, 2024 and 2023. Future minimum required lease payments under the lease agreement are as follows:

Year ending December 31,	
2025	$ 99,543
2026	99,543
2027	99,543
2028	99,543
Total	$ 398,172

Note 7. Participation in Multiemployer Plans

Defined Benefit Pension Plan

All of the Plan's employees are covered by a multiemployer defined benefit pension plan. The risk of participating in a multiemployer defined benefit pension plan is different from a single employer plan. 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 a multiemployer defined benefit pension plan, the unfunded obligations of that plan may be borne by the remaining participating employers.

Note 7. Participation in Multiemployer Plans (continued)

Defined Benefit Pension Plan (continued)

The Plan's participation in the multiemployer defined benefit pension plan for the years ended December 31, 2024 and 2023 is outlined in the following table. A plan that is considered to be significant is 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. Amount other factors, plans in the red zone status are below 65 percent funded, plans in the yellow zone are between 65 and 80 percent funded, and plans in the green zone are at least 80 percent funded. The "FIP/RP Status" column indicates whether a funding improvement plan (FIP) or rehabilitation plan (RP) is either pending or has been implemented. 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 2024	Pension Protection Act Zone Status 2023	FIP/RP Status	Contributions 2024	Contributions 2022	Most Recently Available Annual Report (Form 5500)
Suburban Teamsters of Northern Illinois Pension Fund	36-6155778/001	Green as of 1/1/25	Green as of 1/1/24	Implemented	$ 215,202	$ 196,411	12/31/2023

Contributions to the plan are made monthly under the terms of a participation agreement. The Plan's contributions do not represent more than 5% of total contributions to the plan as indicated in the plan's most recently available annual report.

Welfare Plan that Provides Postretirement Benefits

All Plan employees are also covered by a multiemployer welfare plan that provides health benefits to retirees and to eligible employees working under collective bargaining agreements, and their dependents. Contributions to this plan for the years ended December 31, 2024 and 2023 totaled $279,966 and $256,267 respectively.

Note 8. Concentration of Cash

Cash consists of monies held in checking accounts without significant withdrawal restrictions. The Plan places its cash with financial institutions deemed to be creditworthy. Balances are insured by FDIC up to $250,000 per financial institution. At December 31, 2024, the Plan held cash balances in excess of federally insured limits of approximately $7,465,000.

Note 9. 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.

Due to the inherent uncertainties involved in the valuations of investment that are not publicly traded, estimated fair values may differ materially from the values that would have been used had a ready market for the underlying securities existed.

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

Note 10. Funding Policy

The Plan is primarily funded by employer contributions and by contributions from participants electing self-pay or COBRA coverage. Additionally, with limited exceptions, the Plan receives self-pay contributions from retired participants.

Employer

The employer contribution rates are specified in the respective collective bargaining agreements. Weekly contribution rates for the years ended December 31, 2024 and 2023 ranged from $433 to $476 and from $423 to $468 respectively. Hourly contribution rates for the years ended December 31, 2024 and 2023 ranged from $11.65 to $11.73 and from $11.15 to $11.23 respectively.

COBRA

Participant contributions are allowed to provide COBRA benefits to active and disabled participants. Participant contributions to provide benefits under COBRA are paid at monthly rates ranging from $452 to $2,072 for the years ended December 31, 2024 and 2023, depending on the coverage options selected.

Note 10. Funding Policy (continued)

Self-Pay

Participants are allowed to self-pay short hours to extend eligibility. Weekly self-pay rates for active participants ranged from $104 to $220 for the years ended December 31, 2024 and 2023, depending on class.

Retired participants are required to make monthly contributions for benefits under the Plan, excluding the basic plan coverage election. For the comprehensive and supplemental coverage options, the monthly rate ranged from $300 to $1,030 for the years ended December 31, 2024 and 2023, depending on specific coverage options selected. Effective April 1, 2022, certain retirees enrolled in Medicare Part B may qualify for $0 premium coverage provided certain other requirements are met.

Note 11. Postretirement Benefit Obligations

The Plan provides hospital and major medical coverage for eligible retirees. Retirees contributed approximately 42% and 41% of the estimated cost of providing their postretirement benefits for the years ended December 31, 2024 and 2023, respectively. These benefits covered 954 and 909 retirees as of December 31, 2024 and 2023, respectively. Current participants qualify for coverage by satisfying the following requirements:

- Age - At least 55 years of age, eligible for and receiving a Teamster-affiliated pension, or age 62 and receiving Social Security retirement benefits

- Long-term service requirement - At least 10 years (120 months) of coverage under the Plan during the 15 year (180 month) period preceding the effective date of receiving a pension from the Suburban Teamsters of Northern Illinois Pension Fund (Pension Fund) or, if not a participant in the Pension Fund, during the 15 year period preceding the effective date of receiving Social Security retirement benefits. If the pension is a reciprocal pension, which takes into account service in another Teamster-affiliated pension plan, the requirement may apply up to 5 years (60 months) of service in the other pension plan to satisfy the 10 year requirement

- Short-term service requirement - At least nine months of coverage under the Plan during each of the two 12 month periods immediately prior to the effective date of receiving a pension from the Pension Fund or, if not a participant in the Pension Fund, the effective date of receiving Social Security retirement benefits

Participants who were eligible at age 50, or who are disabled, are also eligible for retiree benefits if 1,000 weeks of contributions were made on their behalf.

Note 11. Postretirement Benefit Obligations (continued)

The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing Plan assets.

Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service in the industry rendered to the valuation date.

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

Some of the more significant actuarial assumptions used to calculate the postretirement benefit obligations at December 31, 2024 and 2023 are as follows:

Discount rate:	2024 - 5.40% 2023 - 4.65%
Mortality:	RP-2000 Blue Collar Combined Healthy table (set back one year)
Healthcare trend rate:	2024 - 7.00% assumed to decrease gradually to an ultimate rate of 4% in 2074 and beyond 2023 - 7.25% assumed to decrease gradually to an ultimate rate of 4% in 2074 and beyond

Retirement rates (Percentage of actives who retire at stated age):

Age	Percent
55 - 59	5%
60	25%
61	20%
62	50%
63	60%
64	85%
65	100%

Note 11. Postretirement Benefit Obligations (continued)

The healthcare trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, the obligation would increase by $10,182,000 and $12,648,000 as of December 31, 2024 and 2023, respectively.

The postretirement benefit obligations decreased by $27,835,000 during the year ended December 31, 2024, primarily due to changes in the population. Changes in actuarial assumptions, primarily the change in the discount rate from 4.65% in 2023 to 5.40% in 2024, decreased the postretirement benefit obligation by $7,938,000. Changes in the projected claims costs decreased the postretirement benefit obligation by $8,389,000 during the year ended December 31, 2024.

The postretirement benefit obligations increased by $4,508,000 during the year ended December 31, 2023, due to a change to the projected claims costs. Changes in actuarial assumptions, primarily the change in the discount rate from 4.70% in 2022 to 4.65% in 2023, increased the postretirement benefit obligation by $625,000. Changes in the population decreased the postretirement benefit obligation by $5,260,000 during the year ended December 31, 2023.

The Plan's excess of benefit obligations over net assets relates primarily to the postretirement benefit obligations, the funding of which is not covered by the contributions rate provided by the current bargaining agreement. The Plan empowers the Board of Trustees to increase or decrease annually the amount of self-payments by eligible retired participants, and to modify the terms and conditions under which retiree eligibility may be maintained; therefore, the annual cost of the Plan can be reduced or eliminated prospectively by action of the Board of Trustees.

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

Note 12. 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:

	2024	2023
Net assets available for benefits per the financial statements	$ 145,804,668	$ 141,205,237
Less - benefit obligations currently payable	(9,012,836)	(8,588,496)
Less - HRA reimbursements payable at year end	(10,900)	(24,100)
Net assets available for benefits per the Form 5500	$ 136,780,932	$ 132,592,641

Note 12. Reconciliation of Financial Statements to Form 5500 (continued)

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500 for the year ended December 31, 2024:

Benefits paid to or for participants per the financial statements	$ 74,211,238
Add - amounts currently payable at year end	9,012,836
Add - HRA reimbursements payable at year end	10,900
Less - amounts currently payable at beginning of year	(8,588,496)
Less - HRA reimbursements payable at beginning of year	(24,100)
Benefits paid to or for participants per the Form 5500	$ 74,622,378

Amounts allocated to participants requesting withdrawals from their HRA accounts of $10,900 and $24,100 were recorded on the 2024 and 2023 Form 5500, respectively, for benefit claims that have been processed and approved for payment prior to year end, but not yet paid as of that date.

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS ON SUPPLEMENTAL SCHEDULES

To the Participants and Trustees of
Suburban Teamsters of
Northern Illinois Welfare Fund

We have audited the financial statements of Suburban Teamsters of Northern Illinois Welfare Fund (the Plan) as of and for the years ended December 31, 2024 and 2023, and our report thereon dated August 14, 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 statements as a whole. Supplemental Schedule 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 is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Legacy Professionals LLP

Westchester, Illinois

August 14, 2025

Suburban Teamsters of Northern Illinois Welfare Fund
EIN 36-6158494
Schedule of Investments - Y/E 12/31/24

	COST	FAIR VALUE	
Interest Bearing Cash			
Union National Bank Escrow Account	98,232	98,232	
FNBC Bank & Trust Bank Account	126,287	126,287	
U.S. Bank - Money Market Fund - Robert W. Baird & Co.	189,487	189,487	
Total Interest Bearing Cash	414,006	414,006	
Limited Partnerships			
U.S. Bank - Brigade Loan Offshore Fund, LTD.	15,000,000	18,550,209	
U.S. Bank - Intercontinental U.S. Real Estate Investment Fund	15,521,944	14,195,439	***A***
Total Limited Partnerships	30,521,944	32,745,648	
Common & Collective Trusts			
Prudential Trust Company - Jennison U.S. Small Cap Equity Fund	2,964,939	3,340,756	
Prudential Trust Company - Core Conservative Bond Fund	28,777,434	26,284,995	
Prudential Trust Company - PGIM QS S&P 500 Index Fund	19,940,953	25,611,469	
Total Common & Collective Trusts	51,683,326	55,237,220	
103-12 Investment Entities			
U.S. Bank - IR&M Short Fund LLC	15,513,043	23,569,068	
Registered Investment Companies			
U.S. Bank - Baird Aggregate Bond Fund	8,422,618	19,476,249	
Total		131,442,191	
		14,195,439	***A***

To Schedule H Part IV line 4g

FOOTNOTES STATEMENT 1

SCHEDULE C, PART 2, ITEM D:
THE AMOUNT OF DIRECT COMPENSATION ATTRIBUTABLE TO PLAN EMPLOYEES AND TRUSTEES REPORTED ON SCHEDULE C HAS BEEN DETERMINED IN ACCORDANCE WITH THE DEPARTMENT OF LABOR RULES AND REGULATIONS FOR COMPLETING FORM 5500. THESE AMOUNTS MAY CONSIST OF ELEMENTS CONSIDERED TO BE TAXABLE AS WELL AS NON-TAXABLE AS DETERMINED UNDER THE CURRENT INTERNAL REVENUE CODE.

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 2

NAME	SERVICE CODES
PRUDENTIAL TRUST CO.	19
PRUDENTIAL TRUST CO.	21
PRUDENTIAL TRUST CO.	28
PRUDENTIAL TRUST CO.	52
PRUDENTIAL TRUST CO.	72

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
PREPAID EXPENSES	321,529.	42,111.
PRESCRIPTION REBATES	1,140,536.	1,813,423.
ACCRUED INTEREST AND DIVIDENDS	841.	714.
TOTAL TO SCHEDULE H, LINE 1B(3)	1,462,906.	1,856,248.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 4

DESCRIPTION	BEGINNING	ENDING
DUE TO SUBURBAN TEAMSTERS PENSION	114,147.	70,541.
TOTAL TO SCHEDULE H, LINE 1J	114,147.	70,541.

SCHEDULE H OTHER INCOME STATEMENT 5

DESCRIPTION	AMOUNT
OTHER INCOME	436.
PRESCRIPTION DRUG REBATES	3,882,715.
TOTAL TO SCHEDULE H, LINE 2C	3,883,151.

SCHEDULE H OTHER PAYMENTS TO PROVIDE BENEFITS STATEMENT 6

DESCRIPTION	AMOUNT
OTHER PPO FEES	501,339.
BLUE CROSS BLUE SHIELD ACCESS AND ADMIN FEES	1,774,050.
HOSPITAL UTILIZATION REVIEW FEES	94,668.
DELTA DENTAL ADMINISTRATIVE FEES	84,709.
EYEMED VISION CARE SERVICES ADMINISTRATIVE FEES	38,111.
DIABETES MANAGEMENT FEES	55,350.
TELADOC FEES	56,280.
KROGER PRESCRIPTION ADMIN FEES	66,657.
TOTAL TO SCHEDULE H, LINE 2E(3)	2,671,164.

SCHEDULE H OTHER ADMINISTRATIVE EXPENSES STATEMENT 7

DESCRIPTION	AMOUNT
FIDUCIARY LIABILITY INSURANCE	56,065.
PRINTING AND POSTAGE	104,929.
REAL ESTATE TAXES - REIMBURSED TO RELATED PARTY	17,815.
DEPRECIATION	8,516.
PAYROLL TAXES (INCLUDES DISABILITY CLAIMS)	93,133.
COMPUTER PROGRAMMING FEES	8,573.
MISCELLANEOUS EXPENSE	3,455.
OFFICE SUPPLIES AND EXPENSE	29,229.
REPAIRS AND MAINTENANCE - REIMBURSED TO RELATED PARTY	88,469.
TELEPHONE	21,039.
UTILITIES - REIMBURSED TO RELATED PARTY	15,322.
OTHER INSURANCE	1,375.
OFFICE RENT	99,543.
PCORI FEES	32,522.
COMPUTER CONSULTING	34,906.
TOTAL TO SCHEDULE H, LINE 2I(11)	614,891.

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

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 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
SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/27/1955

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 SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

1171 COMMERCE DRIVE, UNIT 1

WEST CHICAGO IL 60185

2b Employer Identification Number (EIN) 36-6158494

2c Plan Sponsor's telephone number 630-293-5218

2d Business code (see instructions) 484120

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	Signed by: Dominic Romanazzi 35...	10/7/2025	**Dominic Romanazzi**
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	William E. Brach	10/08/2025	**William E. Brach**
	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

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

Form 5500 (2024)
v. 240311

418401 11-25-24

3a Plan administrator's name and address [X] 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**	4,417
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)**	3,508
a (2) Total number of active participants at the end of the plan year	**6a(2)**	3,146
b Retired or separated participants receiving benefits	**6b**	954
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	4,100
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**	428

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

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

9a Plan funding arrangement (check all that apply)
- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

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

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

Form 5500 Schedule H, line 4j - Schedule of Reportable Transactions
Supplemental Schedule 2

Plan Name: Suburban Teamsters of Northern Illinois Welfare Fund
Plan No. 501

Plan Sponsor: Board of Trustees of Suburban Teamsters of Northern Illinois Welfare Fund
EIN: 36-6158494

Y/E 12/31/24

Individual transactions - purchases and sales on separate lines

a. Identity of party involved	b. Description of asset (Include interest rate & maturity in case of a loan)	c. Purchase price	d. Selling price	e. Lease rental	f. Expense incurred with transaction	g. Cost of asset	h. Current value of asset on trans. date	i. Net gain or (loss)
	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A

				Sales	
a. Description of security	b. Total number of purchases	c. Total number of sales	d. Total value of purchases	e. Total value	f. Incr (decr) by
PGIM QS S&P 500 Index Fund IBT - Class 1	2	5	$ 3,250,000	$ 6,250,000	$ 1,447,293