

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

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... B This return/report is: [ ] a single-employer plan [ ] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [ ] automatic extension... 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 HEARTLAND HEALTH AND WELLNESS FUND 1b Three-digit plan number (PN) 501 1c Effective date of plan 01/01/1960 2a Plan sponsor's name (employer, if for a single-employer plan) BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND 2b Employer Identification Number (EIN) 31-6173363 2c Plan Sponsor's telephone number 937-665-1900 2d Business code (see instructions) 445110

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	52816
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	52456
	<b>6a(2)</b>	48345
	<b>6b</b>	311
	<b>6c</b>	0
	<b>6d</b>	48656
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	102

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

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

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

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

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

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

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

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

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

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

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<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>HEARTLAND HEALTH AND WELLNESS FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>31-6173363</b></p>	

**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  
**THE UNION LABOR LIFE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	SL10450	2616	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.

<p><b>(a)</b> Total amount of commissions paid <b>10000</b></p>	<p><b>(b)</b> Total amount of fees paid <b>0</b></p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**THE SEGAL COMPANY (EASTERN STATES) 333 WEST 34TH STREET NEW YORK, NY 10001**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
10000	0	N/A	3

**(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	

**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.

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		933327
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>HEARTLAND HEALTH AND WELLNESS FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>31-6173363</b></p>	

**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  
**SYMETRA LIFE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0742147	68608	01-017696-00	40407	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
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(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.

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....		<b>9a(1)</b>	
(2) Increase (decrease) in amount due but unpaid .....		<b>9a(2)</b>	
(3) Increase (decrease) in unearned premium reserve .....		<b>9a(3)</b>	
(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b> Benefit charges (1) Claims paid .....		<b>9b(1)</b>	
(2) Increase (decrease) in claim reserves .....		<b>9b(2)</b>	
(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>		
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
(G) Other retention charges .....	<b>9c(1)(G)</b>		
(H) Total retention .....	<b>9c(1)(H)</b>		0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	
(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	2719557
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<b>A</b> Name of plan <b>HEARTLAND HEALTH AND WELLNESS FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>31-6173363</b>	

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

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

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

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

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

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

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**BAIRD ADVISORS**

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**39-6037917**

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

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

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

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

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

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

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

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

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

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

COMMUNITY INSURANCE COMPANY

31-1440175

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 49 62	NONE	18824747	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

M&S PRINTMEDIA, INC.

38-3403103

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 38 50	NONE	827321	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BRIDGEWAY BENEFIT TECHNOLOGIES LLC

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	792723	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	6569	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

THE SEGAL COMPANY, INC.

13-1975125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 50	NONE	708378	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	10000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

REINHART BOERNER VAN DEUREN S.C.

39-1126909

(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 50	NONE	680977	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DELTA DENTAL OF OHIO

31-0685339

(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 50	NONE	623176	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SLEVIN & HART P.C

52-1708613

(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 50	NONE	456444	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VIRTA

501 FOLSOM STREET, 1ST FLOOR  
SAN FRANCISCO, CA 94105

(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 50	NONE	282531	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KATY GOZALKA

31-6173363

(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 50	EMPLOYEE	273389	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SIKICH CPA LLC

54-1172176

(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 50	NONE	240086	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RICHARD MAINS

31-6173363

(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 50	EMPLOYEE	213013	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SPECTRUM PRINTING & DESIGN

87-4331704

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 38 50	NONE	205223	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

WILLIAM MCMANUS

31-6173363

(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 50	EMPLOYEE	180765	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VISION SERVICE PLAN

06-1227840

(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 50	NONE	153453	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ERIC MUELLER

31-6173363

(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 50	EMPLOYEE	152058	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SHARI LEWIS

31-6173363

(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 50	EMPLOYEE	117778	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EXPRESS SCRIPTS, INC.

43-1420563

(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 50	NONE	109830	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LAN SOLUTIONS, INC. DBA INTRUST

26-0454565

(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?
50 15	NONE	109795	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

JODI LONG

31-6173363

(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 50	EMPLOYEE	103362	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CARL LOMBARDO

31-6173363

(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 50	EMPLOYEE	99576	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SEAN CHAPMAN

31-6173363

(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 50	EMPLOYEE	95045	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

REBECCA CROW

31-6173363

(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 50	EMPLOYEE	91352	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ANITA GARBER

31-6173363

(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 50	EMPLOYEE	84394	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WILLIAM EVANS

31-6173363

(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 50	EMPLOYEE	83730	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

MISTY JO KESSLER

31-6173363

(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 50	EMPLOYEE	83209	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ERIN GEBHARDT

31-6173363

(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 50	EMPLOYEE	83153	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KRISTA BROSHEARS

31-6173363

(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 50	EMPLOYEE	79309	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

ERICA BASSMAN

31-6173363

(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 50	EMPLOYEE	78282	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ANN RUDD

31-6173363

(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 50	EMPLOYEE	78212	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PAULA ROYSE

31-6173363

(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 50	EMPLOYEE	77713	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MARY CURTIS

31-6173363

(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 50	EMPLOYEE	75515	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BRANDY MULLENIX

31-6173363

(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 50	EMPLOYEE	75294	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KASEY FOREMAN

31-6173363

(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 50	EMPLOYEE	74255	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

HEATHER MILLER

31-6173363

(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 50	EMPLOYEE	74110	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WENDY YOUNG-BURNETT

31-6173363

(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 50	EMPLOYEE	72705	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DARRELL WILKINSON

31-6173363

(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 50	EMPLOYEE	69261	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ANGELA STASTNY

31-6173363

(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 50	EMPLOYEE	68540	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KARRIE SHRINER

31-6173363

(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 50	EMPLOYEE	66448	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

TRACY SMITH

31-6173363

(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 50	EMPLOYEE	64504	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KAYLA GOLDBERG

31-6173363

(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 50	EMPLOYEE	63034	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DELAWARE VALLEY HEALTH CARE COALITI

2980 S HAMPTON RD  
PHILADELPHIA, PA 19154

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 73	NONE	250	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	59018	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

AISHIA FULCHER

31-6173363

(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 50	EMPLOYEE	58239	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STEPHANIE COLLETTE

31-6173363

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30 50	EMPLOYEE	57626	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MARK FEIGLESON

31-6173363

(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 50	EMPLOYEE	56329	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ANGELA OLINGER

31-6173363

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30 50	EMPLOYEE	53606	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JASMINE SIMON

31-6173363

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30 50	EMPLOYEE	49738	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GARNISHA HUDSON

31-6173363

(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 50	EMPLOYEE	42822	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EMILY ANTHONY

31-6173363

(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 50	EMPLOYEE	34985	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FIFTH THIRD BANK RETIREMENT SERVICE

31-1051736

(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?
21 28 50 51	NONE	33175	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

WANDA UNDERWOOD

31-6173363

(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 50	EMPLOYEE	32495	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CARL GABRIEL

31-6173363

(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 50	EMPLOYEE	31125	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BECKY DERHAM

31-6173363

(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 50	EMPLOYEE	28709	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SHARENE MALONEY

31-6173363

(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 50	EMPLOYEE	27817	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JENNIFER POWELL

31-6173363

(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 50	EMPLOYEE	27512	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MONA MANSOOR

31-6173363

(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 50	EMPLOYEE	27446	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LOCKTON

PO BOX 123042  
DALLAS, TX 75312-3042

(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 50	NONE	22500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ZELIS RED-CARD SYSTEMS, LLC

20-5388701

(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 50	NONE	20016	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

NEPC, LLC

26-1429809

(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 72	NONE	20000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NETWORKS GROUP INC.

455 E EISENHOWER PKWY STE 300  
ANN ARBOR, MI 48108

(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 50	NONE	20000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MCKNIGHT, CANZANO, SMITH, RADTKE &

38-2157642

(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 50	NONE	16245	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SEGAL SELECT INSURANCE SERVICES INC

46-0619194

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	12291	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

PAYCORE, INC.

PO BOX 639860  
CINCINNATI, OH 45263-9860

(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 50	NONE	10088	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ONSOLVE LLC

780 WEST GRANADA BLVD  
ORMOND BEACH, FL 32174

(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 50	NONE	5425	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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
DELAWARE VALLEY HEALTH CARE COALITI	22 73	59018
(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.	
DELTA DENTAL OF OHIO  31-0685339	MARKETING BONUS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
SEGAL SELECT INSURANCE SERVICES INC	22 53	10888
(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.	
ULLICO  13-2988846	INSURANCE BROKERAGE COMMISSIONS AND FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
THE SEGAL COMPANY, INC.	11 16	10000
(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.	
THE UNION LABOR LIFE INSURANCE CO  13-1423090	COMMISSION	

**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
BRIDGEWAY BENEFIT TECHNOLOGIES LLC	15 64	6364
(d) Enter name and EIN (address) of source of indirect compensation EPLAN 22-3720767	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INFORMATION MANAGEMENT	
(a) Enter service provider name as it appears on line 2 SEGAL SELECT INSURANCE SERVICES INC	(b) Service Codes (see instructions) 22 53	(c) Enter amount of indirect compensation 1403
(d) Enter name and EIN (address) of source of indirect compensation AMWINS BROKERAGE 13-1963496	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INSURANCE BROKERAGE COMMISSIONS AND FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>HEARTLAND HEALTH AND WELLNESS FUND</b>	<b>B</b> Three-digit plan number (PN) <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>31-6173363</b>

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

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	9059617	1219239
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	10374850	12427132
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>	100555	200726
<b>(3)</b> Other .....	<b>1b(3)</b>	1704742	2193930
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	11242512	3720691
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	19907321	20880886
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>	323301	261762
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	52712898	40904366
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>	35086900	30649800
<b>h</b> Operating payables.....	<b>1h</b>	11147227	6972939
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>	161618	220933
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	46395745	37843672
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	6317153	3060694

**Part II Income and Expense Statement**

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

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	344205850	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	1718726	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		345924576
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	442320	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		442320
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>	900567	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		900567
(3) Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	7911844	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	7913726	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		-1882
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		72998
<b>c</b> Other income .....	<b>2c</b>		582353
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		347920932

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	321426733	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	4276493	
(3) Other .....	<b>2e(3)</b>	17979440	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		343682666
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>	2329611	
(2) Contract administrator fees .....	<b>2i(2)</b>		
(3) Recordkeeping fees .....	<b>2i(3)</b>		
(4) IQPA audit fees .....	<b>2i(4)</b>	240086	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	23140	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	30035	
(7) Actuarial fees .....	<b>2i(7)</b>	752709	
(8) Legal fees .....	<b>2i(8)</b>	1155891	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	3312253	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		7843725
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		351526391

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		-3605459
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		349000
(2) From this plan .....	<b>2l(2)</b>		

**Part III Accountant's Opinion**

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

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

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

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

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

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

(1) Name: SIKICH CPA LLC

(2) EIN: 54-1172176

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

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

**Part IV Compliance Questions**

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

During the plan year:

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

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

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

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

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

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



**HEARTLAND HEALTH & WELLNESS FUND**

CONSOLIDATED FINANCIAL STATEMENTS AND  
INDEPENDENT AUDITOR'S REPORT

For the Years Ended December 31, 2024 and 2023



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**HEARTLAND HEALTH & WELLNESS FUND**  
**TABLE OF CONTENTS**

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	<u>Page(s)</u>
INDEPENDENT AUDITOR’S REPORT .....	3-5
CONSOLIDATED FINANCIAL STATEMENTS	
Consolidated Statements of Net Assets Available for Benefits .....	6
Consolidated Statements of Changes in Net Assets Available for Benefits .....	7-8
Notes to Consolidated Financial Statements .....	9-26
SUPPLEMENTAL SCHEDULES	
Consolidated Schedule of Assets (Held at End of Year) .....	27
Consolidated Schedule of Reportable Transactions .....	28
Consolidated Schedule of Employer Contributions .....	29-31
Consolidated Schedules of Administrative Expenses .....	32

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## **INDEPENDENT AUDITOR'S REPORT**

The Board of Trustees  
Heartland Health & Wellness Fund  
Dayton, Ohio

### **Opinion**

We have audited the accompanying consolidated financial statements of Heartland Health & Wellness Fund (the Fund), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), and Heartland Benefit Plan Administrators LLC (the LLC) which comprise the consolidated statements of net assets available for benefits as of December 31, 2024 and 2023, and the related consolidated statements of changes in net assets available for benefits for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the net assets available for benefits of the Fund and LLC as of December 31, 2024 and 2023, and the changes in its net assets available for benefits for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### **Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of Heartland Health & Wellness Fund and Heartland Benefit Plan Administrators LLC 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 Consolidated Financial Statements**

Management is responsible for the preparation and fair presentation of the consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund and LLC's ability to continue as a going concern within one year after the date that the consolidated financial statements are available to be issued.

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

### **Auditor's Responsibilities for the Audit of the Consolidated Financial Statements**

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated 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 consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund and LLC'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 consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund and LLC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

## Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated schedule of assets (held at end of year) as of December 31, 2024 and the consolidated schedule of reportable transactions for the year ended December 31, 2024 are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. The consolidated schedule of employer contributions and consolidated schedules of administrative expenses are provided for informational purposes only. 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 consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental consolidated schedule of assets (held at end of year) and the consolidated schedule of reportable transactions, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules are fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content of the supplemental consolidated schedule of assets (held at end of year) and the consolidated schedule of reportable transactions are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.



Brookfield, Wisconsin  
October 7, 2025

## **CONSOLIDATED FINANCIAL STATEMENTS**

# HEARTLAND HEALTH & WELLNESS FUND

## CONSOLIDATED STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>ASSETS</b>		
Investments, at fair value	\$ 24,601,577	\$ 31,149,833
Receivables		
Employer contributions	12,427,132	10,374,850
Self-payment contributions	200,726	100,555
Accrued interest	13,964	49,831
Benefit refunds	2,042,747	1,474,600
Shared administrative expenses	59,136	21,604
Other	-	1,069
Total receivables	<u>14,743,705</u>	<u>12,022,509</u>
Cash	<u>1,219,239</u>	<u>9,059,617</u>
Prepaid administrative expenses	<u>78,083</u>	<u>157,638</u>
Office furniture and equipment, net of accumulated depreciation	<u>228,717</u>	<u>161,916</u>
Net operating right-of-use (ROU) assets	<u>33,045</u>	<u>161,385</u>
Total assets	<u>40,904,366</u>	<u>52,712,898</u>
<b>LIABILITIES</b>		
Benefit program costs	6,660,308	10,773,885
Accounts payable for administrative expenses	312,631	373,342
Accrued payroll and payroll taxes	5,860	-
Due to members	1,385	396
Deferred income	180,644	-
Operating lease liabilities	<u>33,044</u>	<u>161,222</u>
Total liabilities	<u>7,193,872</u>	<u>11,308,845</u>
<b>NET ASSETS AVAILABLE FOR BENEFITS</b>	<u>\$ 33,710,494</u>	<u>\$ 41,404,053</u>

See accompanying notes to the consolidated financial statements.

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

For the Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>ADDITIONS IN NET ASSETS ATTRIBUTED TO</b>		
Investment income		
Net appreciation in fair value of investments	\$ 72,998	\$ 321,553
Dividends	900,567	722,119
Interest	442,320	534,055
	<u>1,415,885</u>	<u>1,577,727</u>
Less investment expenses	23,140	23,346
Net investment income	<u>1,392,745</u>	<u>1,554,381</u>
Contributions		
Employer	344,205,850	326,438,465
Self-payment	1,718,726	1,779,163
Total contributions	<u>345,924,576</u>	<u>328,217,628</u>
Other additions		
Loss on disposal of office furniture and equipment	(1,882)	(267)
Shared expense reimbursements	515,401	499,196
Miscellaneous	66,952	305,496
Total other additions	<u>580,471</u>	<u>804,425</u>
Total additions	<u>347,897,792</u>	<u>330,576,434</u>

(This statement is continued on the following page.)

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS (Continued)

For the Years Ended December 31, 2024 and 2023

	2024	2023
<b>DEDUCTIONS FROM NET ASSETS</b>		
<b>ATTRIBUTED TO</b>		
Benefit program costs		
Claims incurred		
Accident and health	\$ 304,958,666	\$ 277,456,759
Dental	11,247,547	11,487,860
Prescription drugs	7,793,875	7,294,936
Vision care	1,842,745	1,872,754
Death benefits	21,000	26,450
Total claims incurred	325,863,833	298,138,759
Dental administrative fees	623,176	667,513
Life premiums	2,719,557	2,803,757
Stop-loss premiums	933,760	967,862
Prescription drug program expenses	110,080	60,593
Vision service plan program expenses	153,453	176,331
Preferred provider network, medical review, and case management fees	17,715,907	18,493,625
Total benefit program costs	348,119,766	321,308,440
Administrative expenses	7,820,585	7,274,446
Total deductions	355,940,351	328,582,886
NET (DECREASE) INCREASE BEFORE PLAN TRANSFERS	(8,042,559)	1,993,548
Transfer of net assets from South Central UFCW Unions and Employers Health & Welfare Trust Fund (Note 7)	349,000	-
NET ASSETS AVAILABLE FOR BENEFITS, BEGINNING OF YEAR	41,404,053	39,410,505
<b>NET ASSETS AVAILABLE FOR BENEFITS, END OF YEAR</b>	<b>\$ 33,710,494</b>	<b>\$ 41,404,053</b>

See accompanying notes to the consolidated financial statements.

# HEARTLAND HEALTH & WELLNESS FUND

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2024 and 2023

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### 1. DESCRIPTION OF PLAN

The accompanying consolidated financial statements include the accounts of Heartland Health & Wellness Fund (the Fund) and Heartland Benefit Plan Administrators LLC (the LLC) (collectively, the Plan). All significant intercompany balances and transactions have been eliminated in consolidation.

The following description of the Plan provides only general information about the Plan's provisions. Participants should refer to the plan agreement for a complete description of the Plan's provisions, copies of which may be obtained from the plan sponsor.

#### General

The Plan was formed in 1957 by and between union locals affiliated with the United Food and Commercial Workers International Union, AFL-CIO and certain employers to provide for a uniform health and welfare program for employees employed under certain collective bargaining agreements. The Plan provides health and other benefits to eligible members and covered dependents. Retirees are entitled to benefits if they have attained the required eligibility requirements.

The Plan provides certain health and supplemental benefits through a welfare arrangement, which is funded by a voluntary employee's beneficiary association (VEBA) trust fund. The Plan is subject to provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The LLC was formed to provide claims processing, employer billing, record-keeping, and other administrative services to the Plan. The LLC also provides administrative services to the UFCW Heartland Pension Fund, Central Ohio UFCW Unions and Retail Employers Pension Plan, Michigan UFCW Unions and Employers Retiree Health Plan, Michigan UFCW Union and Employers Joint Prepaid Legal Services Plan, and UFCW Local 400 and Employers Health and Welfare Plan. The Operating Agreement for the LLC provides that the Plan's Board of Trustees is the sole member and owner of the LLC. The LLC has a manager who has general oversight of the LLC's activities. While a separate entity, the activities of the LLC are included in these consolidated financial statements per accounting principles generally accepted in the United States of America (US GAAP).

The Plan is administered by a Board of Trustees consisting of a union group and an employer group of representatives, each having equal voting power.

**1. DESCRIPTION OF PLAN (Continued)**

Benefits

The Plan provides health benefits (medical, vision, dental, and prescription drugs), life insurance, short and long-term disability benefits, accidental death and dismemberment benefits, and death benefits. Retirees are entitled to similar health benefits until the earliest of age 65, eligibility for Medicare, or eligibility for Medicaid. One of the retiree plans provides coverage for life. The Plan also provides continuation of certain benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Experience-Rated Contracts

Certain insurance contracts are subject to experience-ratings adjustments. Experience ratings (calculated as the difference between premiums paid and the total of claims paid and fees charged by the insurance company) are determined by the insurance company in the following year and may result in a premium surplus or deficit.

Insured Benefits

The Plan fully insures its life insurance (basic, supplemental, and dependent), and accidental death and disability benefits (basic, supplemental, and spousal). The Plan purchases annual insurance contracts for these insured benefits. Premiums for these benefits are paid to the insurance companies from the assets of the VEBA trust.

Self-insured Benefits

All other Plan benefits are self-insured. The claims for self-insured benefits are processed either by the Plan or by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The third-party claims processors pay claims directly to or on behalf of participants and are then reimbursed by the Plan's VEBA trust. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan.

The Plan utilizes pharmacy benefit managers (PBM) which periodically make refunds to the Plan based on the Plan's actual utilization pattern of specific drugs.

Death Benefits

The Plan has a death benefit available to certain classes of eligible retirees, and the benefit amount ranges from \$500 to \$4,000.

**1. DESCRIPTION OF PLAN (Continued)**

Contributions

The Plan is financed by employer contributions in accordance with collective bargaining agreements in effect between the unions and participating employers. In addition, under certain conditions, the Plan allows for self-payment contributions from participants and retirees. The costs of the postretirement benefit plan are shared by the Plan's participating employers and retirees. In addition to deductibles and copayments, retiree contributions for the years ended December 31, 2024 and 2023 ranged from \$0 to \$2,455 depending upon retirement date, type of coverage, and years of credited service. For the years ended December 31, 2024 and 2023, the retiree contributions are an estimated 21% of the projected cost of providing their postretirement benefits.

The Kroger employer groups are participating employers of the Plan under a "pass-through" arrangement. Under the pass-through arrangement, employers pay their share of Plan benefits and administrative expenses in lieu of employer contributions. The Plan invoices these Kroger groups on a weekly basis for any direct expenses, both benefits and administrative, as incurred. On a monthly basis, a portion of the remaining administrative expenses are invoiced based on the number of eligible members. Also on a monthly basis, these Kroger groups are credited for COBRA contributions, refunds, voids, and other miscellaneous receipts received by the Plan. For accounting purposes these reimbursements are considered employer contributions.

Employer and participants' contributions are received from employers and participants for the operation of the Plan. Employer contributions are recognized in the period that coincides with the completion of the related work hours. Participant contributions are recognized in the period of benefit coverage.

Stop Loss Coverage

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured medical benefits for the independent and non-Medicare retiree groups. Under this policy, the Plan will be reimbursed for claims paid in excess of \$500,000 per individual per policy year.

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

Basis of Accounting

The accompanying consolidated financial statements are prepared, and the books of record are maintained, on the accrual basis of accounting.

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Use of Estimates

The preparation of consolidated financial statements in conformity with US GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, estimated health claims incurred but not reported (IBNR), postretirement benefit obligations and changes therein, and disclosure of contingent assets and liabilities. Accordingly, actual results could differ from those estimates. Estimates that are particularly susceptible to significant change in the near-term are the liabilities for IBNR and the postretirement benefit obligations. Although it is not possible to measure the degree of variability inherent in these estimates, management believes that the liabilities reported are adequate. Any adjustment determined to be necessary is reflected in current operations.

Cash

Cash is defined as currency on hand, in demand deposits.

Concentrations

Credit risk - The Plan maintains its cash balance in financial institutions, which at times may exceed federally insured limits. As of December 31, 2024 and 2023, the Plan had \$1,777,472 and \$9,538,478, respectively, deposited in excess of the Federal Deposit Insurance Corporation insurance limits. The Plan has not experienced any losses in such accounts and believes it is not exposed to any significant credit risks on cash.

Employer contributions - The Plan has one employer which accounted for approximately 89% of total employer contributions for the years ended December 31, 2024 and 2023.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Board of Trustees determines the Plan's valuation policies and procedures utilizing information provided by the investment adviser and custodian. See Note 5 for a discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes gains and losses on investments bought and sold as well as held during the year.

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Payment of Benefits

Premiums paid by the Plan are recorded as premiums in the accompanying consolidated statements of changes in net assets available for benefits.

Claim payments are recorded when paid by the Plan and the third-party claims processors. Amounts due to claims processors that have yet to be reimbursed by the Plan are recorded as benefit program costs in the accompanying consolidated statements of net assets available for benefits. Claim payments are recorded as claims incurred in the accompanying consolidated statements of changes in net assets available for benefits.

Stop-loss Insurance

Premiums for stop-loss insurance are included as benefit program costs in the accompanying consolidated statements of changes in net assets available for benefits. Stop-loss refunds totaling \$438,897 and \$305,270 have been netted with claims incurred in the accompanying consolidated statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023, respectively.

Rebates and Refunds

Refunds due from the Plan's PBM are recorded when known and earned, with the offset being netted against prescription drugs claims incurred. Refunds due as of the financial statement date have been reported as a receivable in the accompanying consolidated statements of net assets available for benefits. Pharmacy rebates totaling \$2,677,442 and \$2,380,670 have been netted with prescription drugs claims incurred in the accompanying consolidated statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023, respectively.

Subrogation and medical refunds are recorded when received. These refunds totaled \$798,074 and \$799,011 for the years ended December 31, 2024 and 2023, respectively. Subrogation and medical refunds are netted with claims incurred in the accompanying consolidated statements of changes in net assets available for benefits.

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Leases

The Plan determines whether an arrangement is a lease at the inception of the arrangement based on the terms and conditions in the contract. A contract contains a lease if there is an identified asset and the Plan has the right to control the asset. As accounting policy elections, the Plan does not apply Accounting Standards Codification 842, *Leases*, to short-term leases (term of 12 months or less), and accounts for non-lease and lease components in a contract as a single component for all asset classes. Right-of-use (ROU) assets represent the Plan's right to use an underlying asset for the lease term and lease liabilities represent the Plan's obligation to make lease payments arising from the lease. ROU assets and liabilities are recognized at the commencement date based on the present value of lease payments over the lease term.

For the Plan's leases where the rate implicit in the lease is not readily determinable, the Plan has elected to apply a risk-free discount rate to determine the present value of lease payments. Lease terms include options to extend the lease when it is reasonably certain those options will be exercised. Leases may contain rent escalations over the lease term, and operating lease expense is recognized on a straight-line basis over the lease term.

The Plan leases office space and office equipment. Operating leases are to be included in operating lease ROU assets, other current liabilities, and operating lease liabilities on the consolidated statements of net assets available for benefits.

The Plan's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Postretirement Benefit Obligations

Postretirement benefits have been recognized for future benefits expected to be paid to or for (a) currently retired or terminated employees and their beneficiaries and dependents, and (b) active employees and their beneficiaries and dependents after retirement from service with the participating employers. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to employee 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 employers and current retirees of the Plan. The obligations represent the amounts that are expected to be funded by contributions from the Plan's participating employers, retirees, and from existing Plan assets. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Postretirement Benefits Obligations (Continued)

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per 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.

For measurement purposes as of December 31, 2024, an 8.30% weighted-average annual rate increase in the average per capita cost of covered medical, prescription, dental, and vision benefits and PPO access fees was assumed; the rate was assumed to decrease gradually to 4.50% over 11 years and remain at that level thereafter. The annual increase in all required retiree contributions was assumed to equal the assumed rate of increase applied to medical claims costs. For measurement purposes as of December 31, 2023, a 7.85% weighted-average annual rate increase in the average per capita cost of covered medical, prescription, dental, and vision benefits and PPO access fees was assumed; the rate was assumed to decrease gradually to 4.50% over 10 years and remain at that level thereafter. The annual increase in all required retiree contributions was assumed to equal the assumed rate of increase applied to medical claims costs.

The following were other significant assumptions used to determine the postretirement benefit obligations as of December 31, 2024 and 2023:

Weighted-average discount rate	5.50% for 2024 and 4.75% for 2023
Postretirement mortality rates	Healthy - Pri-2012 Healthy Annuitant Blue Collar Headcount-Weighted Mortality Table, projected generationally from 2012 with Scale MP-2021 Disabled - Pri-2012 Disabled Retiree Headcount-Weighted Mortality Table, projected generationally from 2012 with Scale MP-2021
Participation and coverage election	85% of participants eligible to retire and receive subsidized postretirement welfare coverage were assumed to elect coverage in the plan. It is assumed that future disabled retirees will be immediately eligible for Medicare. Spouses of future disabled retirees were assumed to not elect coverage in the plan. All current retirees are assumed to remain covered by their current plan. Future retirees are assumed to be covered by Plan B. For 2023, Local 700 Kroger Southern Illinois Meats members were assumed to be covered by Plan A.

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

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Claims Incurred but not Reported

Benefit obligations other than postretirement benefit obligations include health claims currently payable and health claims incurred but not yet reported. Claims paid by the claims processor prior to the year-end that are not reimbursed by the Plan as of year-end are recorded as claims payable and included in claims payable and claims incurred but not reported in the Plan's benefit obligations. See Note 3.

Claims incurred but not yet reported are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the plan administrator. These amounts are paid by the Plan only if claims are submitted and approved for payment.

Health Reimbursement Arrangement

The Plan has a health reimbursement arrangement (HRA) that is funded solely by the Plan after eligible participants complete certain wellness programs. The HRA allows eligible participants to be reimbursed tax free for deductibles and coinsurance. Amounts remaining at the end of the year can generally be carried over to the next year. The Plan is not permitted to refund any part of the balance to participants; the account cannot be used for anything other than reimbursements for qualified medical expenses; and remaining amounts are not portable upon termination or loss of eligibility.

Included in the Plan's benefit obligations in Note 3 are HRA amounts available to reimburse participants for qualifying medical expenses. As of December 31, 2024 and 2023 the HRA balances totaled \$966,331 and \$928,766, respectively. HRA incentive claims paid to participants totaled \$722,531 and \$618,408 for the years ended December 31, 2024 and 2023, respectively, and are included in claims incurred in the accompanying consolidated statements of changes in net assets available for benefits.

**HEARTLAND HEALTH & WELLNESS FUND**  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**3. PLAN'S BENEFIT OBLIGATIONS**

The Plan's benefit obligations as of December 31, 2024 and 2023 are as follows:

	<u>2024</u>	<u>2023</u>
Amounts currently payable to or for participants, beneficiaries, and dependents		
Claims payable	\$ 6,130,000	\$ 7,017,400
Other obligations for current benefit coverage, at present value of estimated amounts		
Claims incurred but not reported	24,519,800	28,069,500
Death and disability benefits	365,600	175,600
	<u>31,015,400</u>	<u>35,262,500</u>
Other obligations		
Health reimbursement arrangement	966,331	928,766
Total obligations other than postretirement benefit obligations	<u>31,981,731</u>	<u>36,191,266</u>
Postretirement benefit obligations		
Current retirees	12,430,347	16,798,274
Active participants fully eligible for benefits	9,973,205	10,350,109
Active participants not yet fully eligible for benefits	22,015,019	23,341,283
Total postretirement benefit obligations	<u>44,418,571</u>	<u>50,489,666</u>
<b>TOTAL PLAN BENEFIT OBLIGATIONS</b>	<u><u>\$ 76,400,302</u></u>	<u><u>\$ 86,680,932</u></u>

The Plan's excess of benefit obligations over net assets at December 31, 2024 and 2023, relates primarily to the postretirement benefit obligations, the funding of which is not covered by the contribution rates provided by the current bargaining agreements. It is expected that the deficiency will be funded through future increases in the collective bargaining agreements.

The weighted-average health care cost trend rate assumption has a significant effect on the amounts as postretirement benefit obligations. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 2024 and 2023 by \$3,766,930 and \$4,403,608, respectively.

**HEARTLAND HEALTH & WELLNESS FUND**  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**4. CHANGES IN PLAN'S BENEFIT OBLIGATIONS**

The changes in the Plan's benefit obligations for the years ended December 31, 2024 and 2023 are as follows:

	<u>2024</u>	<u>2023</u>
Amounts currently payable		
Balance at beginning of year	\$ 36,191,266	\$ 30,585,012
Claims reported and premiums approved for payment, including benefits reclassified from benefit obligations	325,930,791	308,184,145
Claims and premiums paid	<u>(330,140,326)</u>	<u>(302,577,891)</u>
Balance at end of year	<u>31,981,731</u>	<u>36,191,266</u>
Postretirement benefit obligations, net of amounts currently payable		
Balance at beginning of year	50,489,666	55,468,093
Increase (decrease) in postretirement benefits attributable to:		
Service cost	1,168,666	1,221,766
Interest cost	2,321,157	2,668,645
Expected benefits paid net of retiree contributions	(5,649,295)	(6,715,820)
Actuarial experience (gain) loss	(2,705,134)	(1,316,042)
Changes in actuarial assumptions	(1,206,489)	(747,013)
Plan amendments	-	(89,963)
Balance at end of year	<u>44,418,571</u>	<u>50,489,666</u>
<b>TOTAL PLAN BENEFIT OBLIGATIONS</b>	<u><u>\$ 76,400,302</u></u>	<u><u>\$ 86,680,932</u></u>

There was an actuarial experience gain that lowered December 31, 2024 obligations by \$2,705,134. This was the net result of gains and losses due to demographic changes. There was an actuarial experience gain that lowered December 31, 2023 obligations by \$1,316,042. This was the net result of net gains and losses due to demographic changes.

The valuation assumption changes decreased the total benefit obligations as of December 31, 2024 by \$1,206,489 primarily due to increasing the discount rate from 4.75% to 5.50%. Other changes include updating the valuation year per capita health care costs and retiree contribution rates, modifying the future trend on retiree contribution rates and health costs, and modifying the assumed age and participation assumptions of future dependents.

The valuation assumption changes decreased the total benefit obligations as of December 31, 2023 by \$747,013 primarily due to updating the valuation-year per capita health care costs and retiree contribution rates. Other changes include updating the future trend on retiree contribution rates and health costs and decreasing the discount rate from 5.00% to 4.75%.

**4. CHANGES IN PLAN'S BENEFIT OBLIGATIONS (Continued)**

Plan amendments decreased obligations as of December 31, 2023 by \$89,963. Effective January 1, 2024, the Cincinnati, Dayton, Kroger Columbus, and Tri-State (Kroger Valley) medical maximum out-of-pocket expenses were increased.

**5. FAIR VALUE MEASUREMENTS**

The framework for measuring fair value provides 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) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under Topic 820 are described as follows:

Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access at the measurement date.

Level 2: Inputs to the valuation methodology other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, such as:

- a. Quoted prices for similar assets or liabilities in active markets,
- b. Quoted prices for identical or similar assets or liabilities in inactive markets,
- c. Inputs other than quoted prices that are observable for the asset or liability,
- d. Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

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

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

**HEARTLAND HEALTH & WELLNESS FUND**  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**5. FAIR VALUE MEASUREMENTS (Continued)**

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023.

*Cash and cash equivalents:* Valued at the deposit account balances, payable on demand.

*Mutual funds:* Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-ended mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair 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 summarizes by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023:

Description	Assets at Fair Value as of December 31, 2024			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ -	\$ 3,720,691	\$ -	\$ 3,720,691
Mutual funds	20,880,886	-	-	20,880,886
<b>TOTAL</b>	<b>\$ 20,880,886</b>	<b>\$ 3,720,691</b>	<b>\$ -</b>	<b>\$ 24,601,577</b>

Description	Assets at Fair Value as of December 31, 2023			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ -	\$ 11,242,512	\$ -	\$ 11,242,512
Mutual funds	19,907,321	-	-	19,907,321
<b>TOTAL</b>	<b>\$ 19,907,321</b>	<b>\$ 11,242,512</b>	<b>\$ -</b>	<b>\$ 31,149,833</b>

**HEARTLAND HEALTH & WELLNESS FUND**  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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**6. OFFICE FURNITURE AND EQUIPMENT**

The LLC's office furniture and equipment are carried at cost and depreciated over their estimated useful lives ranging from three to seven years. Depreciation is computed using the straight-line method. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation and amortization are removed from the accounts and any resulting gain or loss is recognized. The cost of maintenance and repairs is expensed as incurred.

The LLC's office furniture and equipment as of December 31, 2024 and 2023 are detailed as follows:

	<u>2024</u>	<u>2023</u>
Office furniture and equipment	\$ 551,548	\$ 434,005
Less: Accumulated depreciation	(322,831)	(272,089)
	<u>\$ 228,717</u>	<u>\$ 161,916</u>

Depreciation expense totaled \$66,486 and \$51,293 for the years ended December 31, 2024 and 2023, respectively.

**7. PLAN TRANSFER**

The Fund entered into an asset transfer agreement with the South Central United Food and Commercial Workers Unions and Employers Health and Welfare Trust Fund (South Central Fund). The agreement was effective December 10, 2024. The South Central Fund transferred \$349,000 to the Heartland Fund, which were assets allocable to participants covered by collective bargaining agreements between Kroger and Local 540. There was a subsequent transfer in February 2025 from the South Central Fund of \$65,588 in residual assets to the Heartland Fund allocable to the same collectively bargained participants.

**8. PENSION AND POSTRETIREMENT BENEFIT PLANS**

The LLC offers a defined contribution pension plan as defined under Section 401(k) of the IRC covering all employees. The LLC makes matching contributions for salaried employees equal to the employees' contributions up to 4% of the individual employee's compensation. Employer contributions during the years ended December 31, 2024 and 2023 were \$52,095 and \$57,621, respectively.

The LLC is a participating employer in a separate trustee-managed multiemployer defined benefit pension plan, the Pension Fund of Local 227, for employees who participate in collective bargaining agreements. The plan generally provides retirement benefits to employees based on years of service to the LLC. The multiemployer pension plan is managed by a board of trustees. Although the LLC is not represented on the plan's board of trustees, other contributing employers are members of the other plan's board. Contributions of \$75,212 in 2024 and \$76,748 in 2023 were charged to pension expense for ongoing participation in this pension plan.

**HEARTLAND HEALTH & WELLNESS FUND**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

**8. PENSION AND POSTRETIREMENT BENEFIT PLANS (Continued)**

The risks of participating in this multiemployer defined benefit pension plan is different from single-employer plans because: (a) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (b) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be required to be borne by the remaining participating employers, and (c) if the LLC chooses to stop participating in the multiemployer plan, it may be required to pay a withdrawal liability to the plan. In connection with ongoing renegotiation of collective bargaining agreements, the LLC may discuss and negotiate for the complete or partial withdrawal from the multiemployer pension plan. Depending on the number of employees withdrawn in any future period and the financial condition of the multiemployer plan at the time of withdrawal, the associated withdrawal liability could be material to the Plan's change in net assets in the period of the withdrawal. The LLC has no plans to withdraw from the Pension Fund of Local 227.

Name of Pension Fund	EIN and Plan Number	Pension Protection		FIP/RP Status	Contributions for the Year Ended December 31,		Surcharge Imposed	Expiration of Collective Bargaining Agreement
		Act Zone	Status		2024	2023		
		2024	2023		2024	2023		
Plan A	61-6054018 Plan No. 001	Green	Green	N/A	\$ 75,212	\$ 76,748	No	N/A

**Plan A - Pension Fund of Local 227**

The LLC is obligated for minimum contributions of \$1 per hour to Plan A. Based on the most recently available Form 5500 for Plan A (plan year ended October 31, 2024), the LLC did not contribute more than 5% of total contributions to the plan.

**9. TAX STATUS**

The trust established under the Plan to hold the Plan's assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) and is, therefore, not subject to tax under present income tax laws. The trust has obtained a favorable tax determination letter from the Internal Revenue Service (IRS) and the Trustees believe that the trust and the Plan, as amended, continues to qualify and to operate as designed.

US GAAP requires plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain tax position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

**HEARTLAND HEALTH & WELLNESS FUND**  
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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**10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500**

The following is a reconciliation of net assets available for benefits per the financial statements to Form 5500 as of December 31, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 33,710,494	\$ 41,404,053
Less: Benefit obligations currently payable	<u>30,649,800</u>	<u>35,086,900</u>
NET ASSETS PER THE FORM 5500	<u>\$ 3,060,694</u>	<u>\$ 6,317,153</u>

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

	<u>2024</u>	<u>2023</u>
Claims incurred per the financial statements	\$ 325,863,833	\$ 298,138,759
Add: Benefit obligations current payable at year-end	30,649,800	35,086,900
Less: Benefit obligations current payable at prior year-end	<u>(35,086,900)</u>	<u>(27,989,700)</u>
BENEFITS PAID DIRECTLY TO PARTICIPANTS OR BENEFICIARIES PER THE FORM 5500	<u>\$ 321,426,733</u>	<u>\$ 305,235,959</u>

Amounts currently payable to or for participants, dependents, and beneficiaries are recorded on Form 5500 for benefit claims that have been processed and approved for payment prior to December 31, 2024 but not yet paid as of that date.

**11. TERMINATION OF THE PLAN**

Although they have not expressed any intention to do so, the Unions and employers, by joint agreement, have the right under the Plan to modify the benefits provided to and contributions required of participants, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants. No assets of the Plan may revert to the Unions and employers for purposes other than for the exclusive benefit of the Plan's participants.

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

**13. LEASES AND RELATED PARTY TRANSACTIONS**

Related Party - Lessee

The LLC leases its office and data center from the UFCW Local Union No. 75 (the Local). The lease is effective August 1, 2019 for a term of five years and is a gross lease with monthly rent of \$14,260. Upon merger with Central Ohio Health in 2019, the LLC maintained a satellite office in Columbus, Ohio. The LLC and UFCW Union Local 1059 agreed to a month-to-month lease beginning August 1, 2019 for \$622 per month until January 2023. Total rent expense was \$174,036 and \$171,745 for the years ended December 31, 2024 and 2023, respectively.

Unrelated Party - Lessee

The LLC leases various office equipment with terms up to 63 months and lease costs ranging from \$597 to \$1,769 per month.

**HEARTLAND HEALTH & WELLNESS FUND**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

**13. LEASES AND RELATED PARTY TRANSACTIONS (Continued)**

The components of lease expense were as follows:

<b>Year Ended December 31,</b>	<b>2024</b>	<b>2023</b>
Operating lease cost	\$ 129,186	\$ 227,430

Other information related to leases was as follows:

<b>Year Ended December 31,</b>	<b>2024</b>	<b>2023</b>
Supplemental cash flows information		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	\$ 129,024	\$ 227,485
Right-of-use assets obtained in exchange for lease obligation:		
Operating leases	101,426	608,122
Weighted average remaining lease term:		
Operating leases	1.6 years	1.2 years
Weighted average discount rate:		
Operating leases	1.42%	1.09%

Future minimum lease payments under non-cancellable leases as of December 31, 2023 were as follows:

<b>Year Ending December 31,</b>	<b>Operating Leases</b>
2025	\$ 23,894
2026	7,159
2027	2,386
Total future minimum lease payments	33,439
Less imputed interest	(395)
<b>TOTAL</b>	<b>\$ 33,044</b>

<b>Reported as of December 31,</b>	<b>2024</b>	<b>2023</b>
Operating lease right-of-use assets	\$ 101,426	\$ 608,122
Accumulated amortization	(68,381)	(446,737)
<b>NET OPERATING ROU ASSETS</b>	<b>\$ 33,045</b>	<b>\$ 161,385</b>
Current operating liabilities	\$ 23,595	\$ 128,177
Noncurrent operating lease liabilities	9,449	33,045
<b>TOTAL OPERATING LEASE LIABILITIES</b>	<b>\$ 33,044</b>	<b>\$ 161,222</b>

**13. LEASES AND RELATED PARTY TRANSACTIONS (Continued)**

As described in Note 1, the Plan has an administrative services agreement with the LLC. The LLC also has an administrative services agreement with other employee benefit plans. The Plan shares some common Trustees and employees with the other benefit plans. Under this arrangement certain administrative expenses are shared by the plans based on an allocation methodology approved by the Board. Administrative costs attributable to only one plan are paid directly by that plan. The shared administrative expenses were \$515,401 and \$499,196 for the years ended December 31, 2024 and 2023, respectively. As of December 31, 2024 and 2023 the amounts owed to the LLC were \$83,778 and \$42,656, respectively.

Certain Plan investments are managed by Fifth Third Bank, the custodian; therefore, these transactions qualify as party-in-interest. These are transactions for which a statutory exemption exists under ERISA.

**14. SUBSEQUENT EVENT**

The Plan has evaluated subsequent events through October 7, 2025, which was the date that these financial statements were available for issuance and noted the following subsequent events:

The Fund entered into a merger agreement effective January 1, 2025 with the UFCW Local 400 and Employers Health and Welfare Plan (Local 400 Fund). The Local 400 Fund transferred cash of \$1,501,444, net assets of \$1,222,299, and postretirement benefit obligations of \$83,389,878. As a result of the merger, the Local 400 Fund no longer had any employees on whose behalf contributions were being made to the UFCW International Union – Industry Pension Fund (National Fund) and triggered a withdrawal from the National Fund. As a result, the National Fund calculated an assessed withdrawal liability of \$0.

**SUPPLEMENTAL SCHEDULES**

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED SCHEDULE OF ASSETS (HELD AT END OF YEAR) FORM 5500, SCHEDULE H, ITEM 4i

EIN: 31-6173363      PLAN: #501

December 31, 2024

(a)	(b) Identity of Issue, Borrower, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost	(e) Current Value
<b>Cash and Cash Equivalents</b>				
	Federated Treasury Obligation	Institutional Shares	\$ 3,048,975	\$ 3,048,975
*	Fifth Third	Banksafe Trust	671,714	671,714
	Uninvested Cash		2	2
	Total cash and cash equivalents		3,720,691	3,720,691
<b>Mutual Funds</b>				
	Baird	Ultra Short Bond Fnd Instl.	6,322,670	6,381,486
	Vanguard	Short Term Gov Bond Index Fund	6,309,762	6,188,994
	Vanguard	Short Term Corp Bond Index Fund	8,075,629	8,310,406
	Total mutual funds		20,708,061	20,880,886
<b>TOTAL INVESTMENTS</b>			<b>\$ 24,428,752</b>	<b>\$ 24,601,577</b>

\* Party-in-interest as defined by ERISA

See accompanying notes and independent auditor's opinion.

**HEARTLAND HEALTH & WELLNESS FUND**

CONSOLIDATED SCHEDULE OF REPORTABLE TRANSACTIONS  
FORM 5500, SCHEDULE H, ITEM 4j

EIN: 31-6173363      PLAN: #501

December 31, 2024

The following series of transactions exceeded 5% of the fair value of Plan assets at January 1, 2024:

(a) Identity of Party Involved	(b) Description of Assets, Interest Rate and 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 Transaction Date	(i) Net Gain (Loss)
	Cash and cash equivalents							
Federated Treasury Obligation	Institutional Shares (9 transactions) (3 transactions)	\$ 340,777	\$ -	\$ -	\$ -	\$ 340,777	\$ 340,777	\$ -
		-	7,896,099	-	-	7,896,099	7,896,099	-

See accompanying notes and independent auditor's opinion.

# HEARTLAND HEALTH & WELLNESS FUND

## CONSOLIDATED SCHEDULE OF EMPLOYER CONTRIBUTIONS

For the Year Ended December 31, 2024

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American Business Technologies	\$ 20,454
AVI Foodsystems, Inc.	20,454
Banks Grocery Company	318,011
Bennet Allen	35,112
Billow Construction Inc	1,840
Blue Grass Quality Meats	107,819
Bridgetown Finer Meats	150,099
Brush & Ladder Painting Inc	22,077
C-FAB LLC	62,097
Champaign Residential Services	140,893
Cincinnati AFL-CIO Labor Council	20,454
Cincinnati Interfaith Workers	40,908
Cincinnati Pool Professionals LLC	29,952
Consolidated Healthcare Solutions LLC	16,032
Cundiff Town & Country Tree	36,156
CVS - Cincinnati/Dayton	5,077,652
CVS - Columbus	8,860,708
Cygnat Financial Planning, Inc.	174,318
Darling Ingredients Inc	114,743
Dawn Foods	1,947,088
Law office of Deborah J. Stone	28,587
DBM & Sons Inc.	18,398
Don Carter Associates Inc	35,112
Ellen C Torbeck DMD, PSC	41,528
Frank Harter & Sons Inc	8,523
Fresh Encounter - Chief Supermarkets	892,245
Fresh Encounter - Great Scot	28,964
Frozen Specialties Inc	637,219
G&G Transportation Services Inc	7,485
Genacross Lutheran Services	358,158
George F Moeller LPA	52,084
Giant Eagle	288
Good Shepherd	677,465
Grace Foods Inc	287,871
Graphic Finishing LLC	20,454
Gregory Bellman Atty at law	22,077
Harbor Inc	2,722,980
Harding and Hill Inc.	408,255
Heartland Benefit Plan Administrators LLC	28,741
Hilltop Physicians Inc	23,011
Hollywood Supermarkets	1,648,755
IAM Local Lodge 1943	10,326
Industrial Mechanical Contractors Inc	79,098
Jackson House LLLP	76,788
James Weingartner	11,064
JAS Electric LLC	20,652
Jim Bitzenhofer Refrigeration	167,376
John Stehlin & Sons Co, Inc.	35,205
Kissel Brothers Shows Inc	20,454

(This schedule is continued on the following page.)

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED SCHEDULE OF EMPLOYER CONTRIBUTIONS (Continued)

For the Year Ended December 31, 2024

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Kroger Co - Bourbonnais	\$ 553,864
Kroger Co - Cincinnati	66,521,783
Kroger Co - Columbus	59,166,125
Kroger Co - Columbus Retirees	22,886,849
Kroger Co - Dallas	6,206,132
Kroger Co - Illinois	4,012,726
Kroger Co - Indiana	43,819,652
Kroger Co - Indy/Cincy	351,467
Kroger Co - Louisville	36,568,774
Kroger Co - Michigan 876	40,887,198
Kroger Co - Michigan 951	2,807,406
Kroger Co - Retirees	5,158,094
Kroger Co - So Ill Clerks	3,550,369
Kroger Co - So Ill Meats	216,485
Kroger Co - Taylorville	463,763
Kroger Co - Toledo	10,659,142
Kroger Co - Tri State	2,808,401
Kroger Co - West Virginia	8,879
Kuhl Tile & Marble	32,304
Langen Meats Inc	113,562
Lawrence County Career & Tech Center	48
Lee Williams Meats Inc	214,799
Leonard A Bleh LLC	130,901
Manley Burke LPA	313,114
Maxwell Medical LLC	33,192
Michael Kelly Realty	11,064
Michael Weber	29,532
Mullen-Van Houten Inc	20,454
Oleson's Food Stores	759,592
Our Harvest Cooperative	513
Peaslee Neighborhood Center, Inc.	49,986
Pipco LLC	11,079
Prairie Farms Dairy	1,095,770
Robert Wholey & Co Inc	908
Rudolph Foods Company	1,830,248
Russell Immigration Law Firm	40,366
Seven Hills Coffee Company	60,839
Silgan Containers	2,796,409
Sky Haven Farms Inc	29,653
Smartcat Marketing Solutions	59,484
Snyder & Gast LLC	18,440
Spectrum Printing and Design	44,256
Sysco	5,336
UFCW Local 1059	1,252,611
UFCW Local 1776 KS	720

(This schedule is continued on the following page.)

**HEARTLAND HEALTH & WELLNESS FUND**

**CONSOLIDATED SCHEDULE OF EMPLOYER CONTRIBUTIONS (Continued)**

For the Year Ended December 31, 2024

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UFCW Local 227	\$ 253,278
UFCW Local 23 FCU	48
UFCW Local 75	1,036,451
UFCW Local 876	596,205
UFCW Local 951	775,641
Wassler Meats, Inc.	164,690
We Care Food Stores, Inc.	88,712
Wisconsin Vision	<u>122,506</u>
<b>TOTAL EMPLOYER CONTRIBUTIONS</b>	<b><u><u>\$ 344,205,850</u></u></b>

See accompanying notes and independent auditor's opinion.

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED SCHEDULES OF ADMINISTRATIVE EXPENSES

For the Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Operational expenses		
Auditing and accounting fees	\$ 240,086	\$ 163,415
Bank service charges	30,035	19,096
Computer system support	946,836	932,286
Consulting fees	752,709	594,904
Depreciation, office furniture and equipment	66,486	51,293
Employee pension expenses	127,307	134,517
Insurance		
Bonding and liability	21,394	11,071
Fiduciary responsibility	63,398	67,522
Workmen's compensation and general	30,518	48,361
Legal fees and expenses	1,155,891	1,119,927
Meeting and educational program expenses	163,979	147,864
Office equipment rental, repairs, and maintenance	60,880	59,038
Office rent	174,036	171,745
Payroll taxes	188,192	192,895
Postage	129,496	146,356
Printing, stationery, and office expenses	1,166,028	763,103
Salaries	2,329,611	2,480,514
Telephone	36,145	34,960
Unclassified	-	4,119
Total operational expenses	<u>7,683,027</u>	<u>7,142,986</u>
Governmental fees and assessments	<u>137,558</u>	<u>131,460</u>
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<u><u>\$ 7,820,585</u></u>	<u><u>\$ 7,274,446</u></u>

See accompanying notes and independent auditor's opinion.


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

<b>Part II</b>	<b>Basic Plan Information—enter all requested information</b>
<b>1a</b>	Name of plan HEARTLAND HEALTH AND WELLNESS FUND
<b>1b</b>	Three-digit plan number (PN) ▶ 501
<b>1c</b>	Effective date of plan 01/01/1960
<b>2a</b>	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  BOARD OF TRUSTEES OF THE HEARTLAND HEALTH AND WELLNESS FUND  7250 POE AVENUE, SUITE 300  DAYTON OH 45414
<b>2b</b>	Employer Identification Number (EIN) 31-6173363
<b>2c</b>	Plan Sponsor's telephone number 937-665-1900
<b>2d</b>	Business code (see instructions) 445110

**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.

<b>SIGN HERE</b>	Signed by:  <small>10A8E1C711313430...</small> Signature of plan administrator	10/7/2025	BOB BLAIR
<b>SIGN HERE</b>	Signature of employer/plan sponsor	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Signature of DFE	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	52,816
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ..... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	52,456
	<b>6a(2)</b>	48,345
	<b>6b</b>	311
	<b>6c</b>	0
	<b>6d</b>	48,656
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	102

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

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

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

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

**a Pension Schedules**

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

**b General Schedules**

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

**HEARTLAND HEALTH & WELLNESS FUND**

CONSOLIDATED SCHEDULE OF REPORTABLE TRANSACTIONS  
FORM 5500, SCHEDULE H, ITEM 4j

EIN: 31-6173363      PLAN: #501

December 31, 2024

The following series of transactions exceeded 5% of the fair value of Plan assets at January 1, 2024:

(a) Identity of Party Involved	(b) Description of Assets, Interest Rate and 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 Transaction Date	(i) Net Gain (Loss)
	Cash and cash equivalents							
Federated Treasury Obligation	Institutional Shares (9 transactions) (3 transactions)	\$ 340,777	\$ -	\$ -	\$ -	\$ 340,777	\$ 340,777	\$ -
		-	7,896,099	-	-	7,896,099	7,896,099	-

See accompanying notes and independent auditor's opinion.

## HEARTLAND HEALTH & WELLNESS FUND

### CONSOLIDATED SCHEDULE OF ASSETS (HELD AT END OF YEAR) FORM 5500, SCHEDULE H, ITEM 4i

EIN: 31-6173363      PLAN: #501

December 31, 2024

(a)	(b) Identity of Issue, Borrower, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost	(e) Current Value
<b>Cash and Cash Equivalents</b>				
	Federated Treasury Obligation	Institutional Shares	\$ 3,048,975	\$ 3,048,975
*	Fifth Third	Banksafe Trust	671,714	671,714
	Uninvested Cash		2	2
	Total cash and cash equivalents		<u>3,720,691</u>	<u>3,720,691</u>
<b>Mutual Funds</b>				
	Baird	Ultra Short Bond Fnd Instl.	6,322,670	6,381,486
	Vanguard	Short Term Gov Bond Index Fund	6,309,762	6,188,994
	Vanguard	Short Term Corp Bond Index Fund	8,075,629	8,310,406
	Total mutual funds		<u>20,708,061</u>	<u>20,880,886</u>
	<b>TOTAL INVESTMENTS</b>		<u>\$ 24,428,752</u>	<u>\$ 24,601,577</u>

\* Party-in-interest as defined by ERISA

See accompanying notes and independent auditor's opinion.