

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
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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: ☒ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☒
D	Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 11/26/1958
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14 2250 S RANCHO DR STE 295 LAS VEGAS, NV 89102-4454
2b	Employer Identification Number (EIN) 88-0087294
2c	Plan Sponsor's telephone number 702-734-8601
2d	Business code (see instructions) 525100

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/09/2025	GRANT DAVIS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 4315
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 4143 6a(2) 4065 6b 6c 6d 4065 6e 6f 4065 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 40

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

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

4A 4B 4D 4E 4F

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

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 6
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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1 Coverage Information:

(a) Name of insurance carrier
HEALTH PLAN OF NEVADA

(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
88-0201035	96342	10000741	501	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

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
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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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☒ Health (other than dental or vision)
b ☐ Dental
c ☒ Vision
d ☐ 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:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	5845206
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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1 Coverage Information:

(a) Name of insurance carrier
LIBERTY DENTAL PLAN OF NEVADA

(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
26-0424586	13566	N10004, N10005	609	10/01/2023	09/30/2024

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

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	

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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

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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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☒ Dental
c ☐ Vision
d ☐ 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:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	355643
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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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	SL 10256	3562	05/01/2024	04/30/2025

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

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
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	(c) Amount	(d) Purpose	

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ 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:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	202203
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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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	G3269, C4534	4038	10/01/2023	09/30/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ 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) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	274200
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(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
23-7089668	53031	02219889	4045	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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
 b ☐ Dental
 c ☒ Vision
 d ☐ 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:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	53442
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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.
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1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL

(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
86-0274899	53597	19048	3436	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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☒ Dental
c ☐ Vision
d ☐ 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:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	143057
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection.
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. ☐ Yes ☒ No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

WELLS FARGO BANK

P O BOX 6995
PORTLAND, OR 97228

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	31094	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CECILIA BACERO

2250 S RANCHO DR #295
LAS VEGAS, NV 89102

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	106947	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CPT COMMERCIAL CLEANING SERVICES

5576 W ROCHELLE AVE #35B
LAS VEGAS, NV 89103

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE OTHER THAN CONTRACT	16800	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PRINCIPAL CUSTODY SOLUTIONS

P.O. BOX 10317
DES MOINES, IA 50306-0317

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19	NONE OTHER THAN CONTRACT	7465	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INTERLINK HEALTH SERVICES, INC.

4660 N.E. BELKNAP COURT, SUITE 209
HILLSBORO, OR 97124

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE OTHER THAN CONTRACT	15767	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALAN D BILLER ASSOCIATES INC

535 MIDDLEFIELD ROAD, SUITE 230
MENLO PARK, CA 94025

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE OTHER THAN CONTRACT	69354	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

A.J. LONGO & ASSOCIATES

253 N LAKE AVE
PASADENA, CA 91101

(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?
23	NONE OTHER THAN CONTRACT	6990	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

THE SEGAL COMPANY

94-1503999

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE OTHER THAN CONTRACT	287921	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PDQ PRINTING

20-3649287

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36	NONE OTHER THAN CONTRACT	77870	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

INNOVATIVE CARE MANAGEMENT

93-1087669

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE OTHER THAN CONTRACT	467265	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HEALTH SERVICES COALITION

88-0492643

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE OTHER THAN CONTRACT	58579	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HARMONY HEALTHCARE

04-3290453

(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 16	NONE OTHER THAN CONTRACT	125561	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ENVISION PHARMACEUTICAL SERVICES

04-0570786

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE OTHER THAN CONTRACT	179454	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CHRISTENSEN, JAMES & MARTIN

88-0330440

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE OTHER THAN CONTRACT	14764	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ANTHEM BLUE CROSS

84-0747736

(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 OTHER THAN CONTRACT	879314	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

INGEN FINANCIAL FORENICS

60 E RIO SALADO PKWAY #900
TEMPE, AZ 85281

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE OTHER THAN CONTRACT	12167	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ZENITH AMERICAN SOLUTIONS

52-1590516

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE OTHER THAN CONTRACT	1574398	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEGAL SELECT INSURANCE

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?
53	NONE OTHER THAN CONTRACT	31045	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EVERSIDE HEALTH GROUP, INC.

1400 WEWATTA STREET
SUITE 350
DENVER, CO 80202

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE OTHER THAN CONTRACT	4020975	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BALDWIN MOFFITT BEHM LLP

46-4370753

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE OTHER THAN CONTRACT	29663	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALSCO

2300 N COMMERCE ST
NORTH LAS VEGAS, NV 89030

(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?
99	NONE OTHER THAN CONTRACT	6726	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

475 VAUGHN, LLC

3430 E. SUNRISE DR. #200
TUCSON, AZ 85718

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE OTHER THAN CONTRACT	136454	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KELLEY LAW GROUP

3800 N CENTRAL AVE #530
PHOENIX, AZ 85012

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	64925	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RUBIN BROWN

43-0765316

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	16000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SUNRIDGE HEIGHTS OFFICE PARK

2739 SUNRIDGE HEIGHTS PKWAY
HENDERSON, NV 89057

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	15198	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

IRON MOUNTAIN

23-2588479

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	NONE	14074	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
	For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
	A Name of plan TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA LOCAL 14	D Employer Identification Number (EIN) 88-0087294	

Part I	Asset and Liability Statement		
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	726260	143901
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	4089305	4356876
(2) Participant contributions.....	1b(2)	313853	324894
(3) Other	1b(3)	145248	1051351
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1640213	667874
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	1959264	1923955
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	23605355	24434905
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	3365044	2617627
f Total assets (add all amounts in lines 1a through 1e)	1f	35844542	35521383
Liabilities			
g Benefit claims payable	1g	13739763	14004877
h Operating payables	1h	354454	302304
i Acquisition indebtedness	1i		
j Other liabilities	1j	613537	534408
k Total liabilities (add all amounts in lines 1g through 1j)	1k	14707754	14841589
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	21136788	20679794

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	50583819	
(B) Participants	2a(1)(B)	3885211	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		54469030
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	53271	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		53271
(2) Dividends:			
(A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	946008	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		946008
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	134331	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		798226
c Other income	2c		10101
d Total income. Add all income amounts in column (b) and enter total	2d		56410967

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	41410473	
(2) To insurance carriers for the provision of benefits	2e(2)	8420237	
(3) Other	2e(3)	4278392	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		54109102
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1663887	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	52152	
(5) Investment advisory and investment management fees	2i(5)	7547	
(6) Bank or trust company trustee/custodial fees	2i(6)	7465	
(7) Actuarial fees	2i(7)	357275	
(8) Legal fees	2i(8)	81032	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	29526	
(11) Other expenses	2i(11)	559975	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2758859
j Total expenses. Add all expense amounts in column (b) and enter total	2j		56867961

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-456994
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) ☒ 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: **BALDWIN MOFFITT BEHM LLP**

(2) EIN: **46-4370753**

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

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

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

TEAMSTERS SECURITY FUND FOR SOUTHERN
NEVADA - LOCAL 14

CONSOLIDATED FINANCIAL STATEMENTS
WITH SUPPLEMENTAL INFORMATION
AND
INDEPENDENT AUDITORS' REPORT
Years Ended December 31, 2024 and 2023

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

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INDEPENDENT AUDITORS' REPORT

To the Board of Trustees

Teamsters Security Fund for Southern Nevada - Local 14

Opinion

We have audited the consolidated financial statements of Teamsters Security Fund for Southern Nevada - Local 14 and its subsidiary, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the consolidated statements of net assets available for benefits and of plan's benefit obligations as of December 31, 2024 and 2023, and the related consolidated statements of changes in net assets available for benefits and of changes in plan's benefit obligations for the years then ended, and the related notes to the consolidated financial statements.

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Teamsters Security Fund for Southern Nevada - Local 14 and its subsidiary and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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 Teamsters Security Fund for Southern Nevada - Local 14's and its subsidiary's ability to continue as a going concern for one year after the date 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 plan; and determining that the plan's transactions that are presented and disclosed in the consolidated financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 consolidated financial statements.

In performing an audit in accordance with generally accepted auditing standards, 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 Teamsters Security Fund for Southern Nevada - Local 14 and its subsidiary'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 Teamsters Security Fund for Southern Nevada - Local 14 and subsidiary'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 Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental schedules of Schedule of Assets (Held at Year End) as of December 31, 2024, and Schedule of Reportable Transactions for the year ended December 31, 2024, together referred to as supplemental information, are presented for the

purposes 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. 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 generally accepted auditing standards

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

October 6, 2025

Baldwin Moffitt Behm LLP

CERTIFIED PUBLIC ACCOUNTANTS
Scottsdale, Arizona

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

CONSOLIDATED STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
ASSETS		
INVESTMENTS, at fair value	\$ 27,026,734	\$ 27,204,832
RECEIVABLES		
Employers' contributions	4,356,876	4,089,305
Participants' contributions	298,658	288,319
Self-pay contributions	26,236	25,534
Due from retiree fund - related party	376,642	-
Due from Local 14 - related party	8,770	-
Interest	31,305	39,665
Other	27,961	18,326
TOTAL RECEIVABLES	<u>5,126,448</u>	<u>4,461,149</u>
FIXED ASSETS, at cost		
Computers	50,577	50,577
Furniture	11,050	11,050
Medical equipment	19,300	19,300
Fixtures	27,566	27,566
Leasehold improvements	731,947	731,947
Building	1,411,269	1,404,574
Land	351,143	351,143
Building improvements	441,569	441,569
Less accumulated depreciation and amortization	<u>(426,794)</u>	<u>(278,430)</u>
FIXED ASSETS, NET	2,617,627	2,759,296
PREPAID EXPENSES	73,415	76,094
DEPOSIT	11,163	11,163
CASH	143,901	726,260
OPERATING LEASE		
RIGHT-OF-USE ASSET, NET	<u>522,095</u>	<u>605,748</u>
TOTAL ASSETS	<u>35,521,383</u>	<u>35,844,542</u>
LIABILITIES		
ACCOUNTS PAYABLE	242,056	251,995
DUE TO RELATED PARTY	-	38,021
OPERATING LEASE LIABILITIES	534,408	613,537
OTHER	31,365	31,365
DUE TO BROKER FOR SECURITIES PURCHASED	<u>28,883</u>	<u>33,073</u>
TOTAL LIABILITIES	<u>836,712</u>	<u>967,991</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>\$ 34,684,671</u>	<u>\$ 34,876,551</u>

The accompanying notes are an integral part of these statements.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
AVAILABLE FOR BENEFITS

Years Ended December 31, 2024 and 2023

	2024	2023
ADDITIONS TO NET ASSETS ATTRIBUTED TO:		
CONTRIBUTIONS		
Employers'	\$ 50,583,819	\$ 47,790,429
Participants'	3,885,211	4,258,234
	<u>54,469,030</u>	<u>52,048,663</u>
INVESTMENT INCOME		
Net appreciation in fair value of investments	932,557	1,386,275
Interest and dividends	999,279	879,251
Rental income	-	59,857
	<u>1,931,836</u>	<u>2,325,383</u>
Less investment expenses	<u>15,012</u>	<u>7,706</u>
	1,916,824	2,317,677
OTHER INCOME	<u>10,101</u>	<u>1,522</u>
TOTAL ADDITIONS	<u>56,395,955</u>	<u>54,367,862</u>
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:		
BENEFITS		
Medical claims	28,447,252	22,611,180
Dental claims	2,811,595	2,587,882
Vision claims	523,550	520,869
Rx claims	9,362,962	9,435,661
Payments to insurance companies	7,753,065	8,187,321
PPO and counseling fees	667,172	491,906
Clinics		
Henderson health & wellness center	1,538,431	1,485,668
Northwest health & wellness center	2,739,961	2,621,808
	<u>53,843,988</u>	<u>47,942,295</u>
ADMINISTRATIVE EXPENSES	<u>2,743,847</u>	<u>2,846,839</u>
TOTAL DEDUCTIONS	<u>56,587,835</u>	<u>50,789,134</u>
NET (DECREASE) INCREASE	(191,880)	3,578,728
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	<u>34,876,551</u>	<u>31,297,823</u>
End of year	<u>\$ 34,684,671</u>	<u>\$ 34,876,551</u>

The accompanying notes are an integral part of these statements.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

CONSOLIDATED STATEMENTS OF PLAN'S BENEFIT OBLIGATIONS

December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE		
Claims payable, claims incurred but not reported and premiums due to insurers	\$ 7,607,277	\$ 6,859,963
Accumulated eligibility credits	<u>6,397,600</u>	<u>6,879,800</u>
PLAN'S TOTAL BENEFIT OBLIGATIONS	<u>\$ 14,004,877</u>	<u>\$ 13,739,763</u>

The accompanying notes are an integral part of these statements.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

CONSOLIDATED STATEMENTS OF CHANGES
IN PLAN'S BENEFIT OBLIGATIONS
Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE		
Balance at beginning of year	\$ 13,739,763	\$ 16,126,611
Claims reported and approved for payment	41,892,673	35,037,144
Claims paid	(41,145,359)	(35,155,592)
Net change during the year	<u>(482,200)</u>	<u>(2,268,400)</u>
Balance at end of year	<u>14,004,877</u>	<u>13,739,763</u>
POSTRETIREMENT BENEFIT OBLIGATIONS, NET OF AMOUNTS CURRENTLY PAYABLE		
Balance at beginning of year	-	18,448,041
Increase during the year attributable to:		
Benefits earned net of benefits paid	-	657,456
Actuarial experience loss	-	(319,080)
Change in actuarial assumptions	-	4,578,717
Plan admendment	-	2,034,188
Transfer of postretirement benefit obligations	<u>-</u>	<u>(25,399,322)</u>
Balance at end of year	<u>-</u>	<u>-</u>
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	<u>\$ 14,004,877</u>	<u>\$ 13,739,763</u>

The accompanying notes are an integral part of these statements.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE A – DESCRIPTION OF FUND

The following description of the Teamsters Security Fund for Southern Nevada - Local 14 (Fund) provides general information only. Participants should refer to the plan agreement for a more complete description of the Fund's provisions.

General - The Trust was formed in 1958 under an agreement to provide health and welfare benefits to participants of employers covered by collective bargaining agreements with Teamsters Local 14 in Southern Nevada (Union). The collective bargaining agreement provides, among other things, for employers of participants to make contributions to the Fund for each participant who is employed on the first day of the work month. The Fund is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

A plan of benefit coverage (Plan) provides for accident, hospital, medical, surgical, vision, dental, disability and death benefits for eligible participants and their dependents as specified in the Plan. Benefit coverage is also provided for certain retired participants as specified therein.

By authorization of the Board of Trustees on February 14, 2019, the Plan adopted Amendment No. 10, effective September 1, 2018, to revise the eligibility under Article III, Sections D and Subsection 2 to revise Section (a) eligibility as a Non-Medicare Retiree. The Non-Medicare Retiree must have been eligible as an Active Employee, or through COBRA, for 90 of the 120 months immediately before retirement. Section (c) was revised to state that up to 30 months of service outside the bargaining unit with the same employer will be counted towards satisfying the 90-month requirement. For new groups or collective bargaining units, active service earned prior to entry into the Plan with the same employer will be counted towards satisfying the 90-month requirement.

By authorization of the Board of Trustees, the Plan adopted amended resolution No. 5, effective April 17, 2023, to allow the Trust to be segregated into Sub-Trusts in accordance with Article II, Section 8. One Sub-Trust shall segregate and hold all payments from Employers and Employees, and any other funds or property which may become part of such sub-trust, for the exclusive purpose of providing benefits to eligible active Employees of Employers contributing to the "Active Sub-Trust". The other Sub-Trust will segregate and hold all payments from Employers and Employees, and any other money or property which may become part of such sub-trust, for the exclusive purpose of providing benefits to eligible former Employees who have retired from active employment with Employers contributing to the "Retiree Sub-Trust". The Active and Retiree Sub-trust shall not be commingled and shall be used only for the specific purposes of that Sub-Trust.

Effective July 1, 2023, the Board created a new retiree sub-trust for Non-Medicare retirees and their dependents which replaces certain benefits currently offered under this Fund. Accordingly, effective July 1, 2023, all postretirement benefit obligations were transferred to the new Trust.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE A – DESCRIPTION OF FUND – continued

T14FWC Group LLC is a separate corporate entity, which is wholly owned by the Fund. The purpose of T14FWC Group LLC is to maintain and operate the real property of Fund which houses a clinic for the use the participants of the Fund.

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Valuation of investments – 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 Fund's trustees determine the Fund's valuation policies utilizing information provided by its investment advisers and custodian. See Note E 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 the Fund's gains and losses on investments bought and sold as well as held during the year.

Basis of accounting - These consolidated financial statements have been prepared utilizing the accrual method of accounting. Under this method of accounting, additions, and deductions to net assets available for benefits are identified with specific periods of time and are recorded as earned and incurred, respectively, without regard to the date of receipt of payment.

The Fund maintains its financial records using the modified cash method of accounting, under which additions and deductions to net assets available for benefits are recognized when measurable and available to finance expenditures of the current period. Expenditures are generally recorded when the liability is paid. Adjustments are prepared at each year-end to adjust the financial records to the accrual method of accounting.

The consolidated financial statements include the accounts of the Teamsters Security Fund for Southern Nevada - Local 14 and its wholly owned subsidiary, T14FWC Group LLC. All material intercompany transactions have been eliminated in the consolidated financial statements.

Contributions – Generally, participating employers contribute monthly contributions for hours worked by employees covered under the Plan at rates specified in agreements entered into with the Union. Electing employees covered under Union agreements have agreed to allocate specific amounts per month from their salaries to maintain benefits as provided under the collective bargaining agreements. Contributions are due the following month after such hours are worked. Participants become eligible for benefits the following month after such contributions are remitted.

A participant must have remitted contributions for three consecutive months for initial eligibility. The self-pay, COBRA, and retiree contribution rates are determined by the trustees and adjusted as necessary.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – continued

Contributions are recorded during each year based upon work months reported by employers. Employers' contributions receivable is based upon actual contributions received subsequent to December 31, for work months prior to December 31st; therefore, there is no allowance for uncollectible receivables. No provision has been made for subsequent receipt of additional delinquent moneys covering work months during December or prior months, as the financial effect is expected to be immaterial. Employer contributions are due by the 20th of the month following the month in which the employee was employed on the first day of the month. Amounts not paid by then are considered delinquent.

Estimates - The preparation of consolidated financial statements in conformity with generally accepted accounting principles requires the Fund administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

The Fund has an obligation to maintain medical coverage for participants who have accumulated eligibility for work performed in November and December where participants would become eligible for benefits in January and February of the subsequent year. The estimated liability is calculated utilizing the estimated costs of benefit coverage.

Under the direct payment plan, in contrast to an insured plan, the actual cost of benefits for a particular period is not known until several months after the close of that period. Therefore, an estimated liability is provided for these claims incurred but not yet reported.

Fixed Asset, Depreciation and Amortization – Fixed Assets are carried at cost. Depreciation and amortization of fixed assets is provided using the straight-line method over the estimated useful lives of the related assets, which range from 5 to 40 years. The Fund does not have a formal capitalization policy. Depreciation expense for the years ended December 31, 2024 and 2023 was \$148,364 and \$114,636 respectively.

Leases – The Fund enters into leases in the normal course of business primarily for its clinic facilities.

Lease are categorized as either operating or finance leases at the commencement date of the lease. Operating lease assets and liabilities are recognized at the lease commencement date. Operating lease liabilities represent the present value of lease payments not yet paid. Operating lease right-of-use (ROU) assets represent the right to use an underlying asset and are based upon the operating lease liabilities adjusted for prepayments or accrued lease payments, initial direct costs and lease incentives. The Fund uses the risk-free borrowing rate based on the information available at commencement date in determining present value of lease payments.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – continued

The Fund recognizes ROU assets and lease liabilities for each lease with contractual terms greater than 12 months at the time of lease inception. Contracts are reviewed for identified assets where the Fund has the right to direct the use of the asset and record those agreements as embedded leases on the Fund's consolidated statements of net assets available for benefits.

The Fund has elected to not recognize leases with original lease terms of 12 months or less (short-term leases) on the Fund's consolidated statements of net assets available for benefits. Disclosures about the Fund's leasing activities are presented in Note H – Leases.

Subsequent events have been evaluated by Fund management through October 6, 2025, which is the date the financial statements were available to be issued.

NOTE C – INCOME TAXES

A determination letter from the Internal Revenue Service dated March 24, 2015, exempts the Fund from Federal income taxes under the provisions of section 501(c)(9) of the Internal Revenue Code. The Fund is also exempt from state income taxes.

The Fund has been amended since receiving its original determination letter from the Internal Revenue Service. However, the Fund Administrator and the Fund's legal counsel believe that the Fund is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, they believe that the Fund is qualified, and the related trust was exempt from income taxes as of the consolidated financial statement date.

Tax years 2022 - 2024 remain subject to examination for federal income tax purposes. The Fund uses a loss contingency approach for evaluating uncertain tax positions. The Fund continually evaluates expiring statutes of limitations, audits, changes in tax laws and new authoritative rulings.

NOTE D – FUND TERMINATION

Although there has not been any expressed intent to do so, in the event the Fund terminates, any and all assets remaining in the Fund after the termination shall be used solely to provide benefits to participants, their families and dependents, and for expenses of administration incident thereto.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE E – FAIR VALUE MEASUREMENTS

Accounting Standards Codification (ASC) No. 820 establishes a framework for measuring fair value. That framework 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 measurement) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under ASC No. 820 are described as follows:

- 1) Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Fund has the ability to access.
- 2) Level 2 - Inputs to valuation methodology include: quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; 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.
- 3) 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. Following is a description of the valuation methodologies used for assets at fair value.

Cash and equivalents - Valued at the closing price reported in the active market in which the individual security is traded.

Mutual funds – Valued at the daily closing price reported by the fund. Mutual funds held by the Fund are open-end mutual funds that are registered with the SEC. These funds are required to publish their daily net asset value (NAV) and to transact at that price. Some of the mutual funds held by the Fund are deemed to be actively traded, others are private funds where NAV is used as a practical expedient to estimate fair value..

Limited partnership – Valued based on the Fund's percentage of ownership of the net assets of the entity based on audited financial statements of the entity, with adjustments to account for partnership activity and other applicable valuation adjustments, where applicable.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE E – FAIR VALUE MEASUREMENTS – continued

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Fund believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date. There have been no changes in the methodologies used at December 31, 2024 and 2023.

The following table sets forth by level, within the fair value hierarchy the Fund's assets at fair value as of December 31, 2024 and 2023:

	Level 1 - Quoted Prices in Active Markets	Level 2 - Significant other Observable Inputs	Level 3 - Significant Unobservable Inputs	Total
<u>December 31, 2024</u>				
Mutual funds	\$ 19,682,591	\$ -	\$ -	\$ 19,682,591
Cash and equivalents	<u>667,874</u>	<u>-</u>	<u>-</u>	<u>667,874</u>
Total assets in fair value hierarchy	<u>20,350,465</u>	<u>-</u>	<u>-</u>	<u>20,350,465</u>
Investments measured at NAV:				
Mutual Fund				4,752,314
Limited partnership	<u>-</u>	<u>-</u>	<u>-</u>	<u>1,923,955</u>
Total investments, at fair value	<u>\$ 20,350,465</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 27,026,734</u>

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE E – FAIR VALUE MEASUREMENTS – continued

	Level 1 - Quoted Prices in Active Markets	Level 2 - Significant other Observable Inputs	Level 3 - Significant Unobservable Inputs	Total
<u>December 31, 2023</u>				
Mutual funds	\$ 23,605,355	\$ -	\$ -	\$ 23,605,355
Cash and equivalents	1,640,213	-	-	1,640,213
Total assets in fair value hierarchy	25,245,568	-	-	25,245,568
Investments measured at NAV:				
Limited partnership	-	-	-	1,959,264
Total investments, at fair value	<u>\$ 25,245,568</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 27,204,832</u>

Fair value of investments that calculate net asset value – The following table summarizes investments measured at fair value based on NAVs per share as of December 31, 2024:

	Fair Value		Unfunded Commitments	Redemption Frequency (if currently eligible)	Redemption Notice Period
	2024	2023			
<i>Limited partnership:</i>					
PGIM Real Estate US Debt Fund, LP (a)	\$1,923,955	\$1,959,264	\$ -	Quarterly	90 Days
<i>Private placement mutual fund</i>					
JPMIT Core Bond Fund (b)	4,752,314	-	-	Daily	1 Day
	<u>\$6,676,269</u>	<u>\$1,959,264</u>	<u>\$ -</u>		

(a) PGIM Real Estate US Debt Fund, LP is a limited partnership whose objective is to invest in real estate and debt-like investments. Redemption is permitted quarterly with notice required 90 days prior to quarter-end.

(b) JPMIT Core Bond Fund is a mutual fund whose objective is to outperform the total return of the Lehman Brothers Aggregate Bond Index (Benchmark) the fund strives to keep overall total return risk similar to the index over a 3-5 year market cycle.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE F – RECONCILIATION OF CONSOLIDATED FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 34,684,671	\$ 34,876,551
Benefit obligations currently payable	<u>(14,004,877)</u>	<u>(13,739,763)</u>
Net assets available for benefits per the Form 5500	<u>\$ 20,679,794</u>	<u>\$ 21,136,788</u>

The following is a reconciliation of benefits paid to participants per the consolidated financial statements to the Form 5500 for the years ended December 31, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Benefits paid to or for participants per the financial statements	\$ 53,843,988	\$ 47,942,295
Add: Amounts payable at end of year	14,004,877	13,739,763
Less: Amounts payable at beginning of year	<u>(13,739,763)</u>	<u>(16,126,611)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 54,109,102</u>	<u>\$ 45,555,447</u>

NOTE G – CONCENTRATION OF CREDIT RISK

The Fund maintains its trust and checking accounts at one financial institution, which at times exceeds amounts covered by insurance provided by the U.S. Federal Deposit Insurance Corporation (FDIC). The Fund has not experienced any losses and believes that it is not exposed to significant credit risk related to cash.

The Fund 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 risks 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 consolidated statements of net assets available for benefits.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE G – CONCENTRATION OF CREDIT RISK – continued

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 assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would-be material to the consolidated financial statements.

NOTE H – LEASES

On January 1, 2019, the Fund entered into a sublease for office space for the Henderson Health & Wellness Center that expired on May 31, 2025. The Fund paid \$175,000 to terminate the lease early effective July 1, 2023. At such time they removed the remaining right-of-use asset and lease liability and recognized lease termination costs of \$178,339 during the year ended December 31, 2023. The sublease required monthly payments of \$7,879 and the Fund was responsible for 50% of the monthly utility costs.

Rent expense for Henderson Health & Wellness Center for years ended December 31, 2024 and 2023 totaled \$ -0- and \$23,817, respectively and are included in clinic expenses on the consolidated statement of changes in net assets.

On February 1, 2019, the Fund entered into a lease agreement for office space for the Northwest Health & Wellness Center that expires on January 31, 2024. On March 11, 2021, the lease was amended when the Fund began renting additional office space. The amendment extended the lease through July 31, 2025, with an option to extend the term for an additional 5 years. On July 21, 2025, the lease was extended for seven years and four months. The lease requires monthly payments of \$7,816 plus 37.64% of operating expenses. The base rent was abated for the first two months of the initial lease. Rent expense for Northwest Health & Wellness Center for years ended December 31, 2024 and 2023 totaled \$140,978 and \$ 98,653, respectively and are included in clinic expenses on the consolidated statement of changes in net assets.

The Fund includes lease extension options in the lease term if, after considering relevant economic factors, it is reasonably certain the Fund will exercise the option. Lease expense is recognized on a straight-line basis over the lease term. Right-of-use assets represent the Fund's right to use an underlying asset for the lease term and the lease liability represents the Fund's obligation to make lease payments arising from the lease.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE H – LEASES – continued

Right-of-use assets and lease liabilities by lease type are as follows:

Right-of-use assets and lease liabilities in the accompanying consolidated statements of net assets available for benefits are as follows:

	<u>Classification</u>	<u>2024</u>	<u>2023</u>
Right-of-use assets:	Operating leases		
Operating leases	Right-of-use assets, net	<u>\$ 522,095</u>	<u>\$ 605,748</u>
Total right-of-use assets		<u><u>\$ 522,095</u></u>	<u><u>\$ 605,748</u></u>
Lease liabilities:			
Operating leases	Operating lease liabilities	<u>\$ 534,408</u>	<u>\$ 613,537</u>
Total lease liabilities		<u>534,408</u>	<u>613,537</u>
Less: current portion		<u>(84,374)</u>	<u>(79,129)</u>
Long-term portion		<u><u>\$ 450,034</u></u>	<u><u>\$ 534,408</u></u>

Future undiscounted lease payments for leases with initial terms of one year or more as of December 31, 2024 are as follows:

December 31, 2025	\$ 96,772
December 31, 2026	98,795
December 31, 2027	101,759
December 31, 2028	104,812
December 31, 2029	107,956
Thereafter	<u>64,063</u>
Total undiscounted lease payments	574,157
Less: imputed interest	<u>(39,749)</u>
Net lease liability	<u><u>\$ 534,408</u></u>

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE H – LEASES – continued

Supplemental lease information:

Weighted-average remaining lease term (years) - operating leases	<u>5.58</u>	<u>6.58</u>
Weighted-average discount rate - operating leases	<u>2.50%</u>	<u>2.50%</u>

NOTE I – RELATED PARTY TRANSACTIONS/PARTIES IN INTEREST

Certain of the Fund's investments represent money market funds and mutual funds managed by Principal Life Insurance Company. Principal Life Insurance Company is the custodial agent as defined by the Fund, and therefore, these transactions qualify as party-in-interest transactions. The Fund also contracts with administrators, attorneys, actuaries and auditors who are all known to be parties-in-interest.

By authorization of the Board of Trustees August 3, 2023, the Fund is to subsidize a portion of the costs for the Teamsters Security Fund for Southern Nevada – Local 14 Non-Medicare Retiree Plan, a related party. The Fund is to allocate \$25 per active member per month to the Non-Medicare Retiree Plan until determined not necessary for the Non-Medicare Retiree Plan. The Subsidy fee paid by the Fund was \$1,187,225 and \$267,600 for the year ended December 31, 2024 and 2023, respectively. In the year ended December 31, 2023, the Fund provided the Non-Medicare Retiree Plan \$500,000 to begin the new plan and to pay for claims that were from prior month and do not expect to have the amount refunded.

NOTE J – CLINIC EXPENSES

In 2019, the Fund opened two Family Wellness Centers in Henderson and Las Vegas, Nevada. There is no out-of-pocket cost for PPO Plan members for services and medication received from the clinics. HMO plan members can use the services and receive medication at the clinics at no cost. The clinics offer primary and acute health and wellness services, preventive care, and medication.

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE K – CLINIC EXPENSES – continued

The following table presents each clinic's expenses for the years ended December 31, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
<u>HENDERSON HEALTH & WELLNESS CENTER</u>		
Lease	\$ -	\$ 23,817
Supplies	5,558	4,217
Everside health	1,505,275	1,429,016
Utilities	5,240	315
Office expense	18,983	21,136
Depreciation	1,077	7,167
Repairs	2,298	-
	<u>\$ 1,538,431</u>	<u>\$ 1,485,668</u>
<u>NORTHWEST HEALTH & WELLNESS CENTER</u>		
Lease	\$ 140,978	\$ 98,653
Supplies	4,209	2,354
Labs expense	-	2,189
Everside health	2,515,700	2,429,504
Security	957	-
Utilities	3,473	6,508
Office expense	18,504	23,579
Depreciation	56,140	59,021
	<u>\$ 2,739,961</u>	<u>\$ 2,621,808</u>

TEAMSTERS SECURITY FUND FOR SOUTHERN NEVADA - LOCAL 14

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended December 31, 2024 and 2023

NOTE L – INVESTMENT AND ADMINISTRATIVE EXPENSES

The following table presents investment and administrative expenses for the years ended December 31, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
<u>INVESTMENT EXPENSES</u>		
Investment management	\$ 7,547	\$ 1,147
Custodial agent	7,465	6,559
	<u>\$ 15,012</u>	<u>\$ 7,706</u>
<u>ADMINISTRATIVE EXPENSES</u>		
Administrative fees	\$ 1,663,887	\$ 1,639,808
Consulting	357,275	356,380
Audit	52,152	18,338
Legal	81,032	68,146
Printing, storage and other	111,642	127,544
Postage and mailing	35,423	37,569
Insurance	41,588	18,296
Payroll audits	5,693	935
Bank fees	29,422	30,953
Meetings and conference expense	29,526	34,501
Salaries	122,977	139,533
Office expense	11,207	7,546
Miscellaneous	44,661	54,158
Building operations	157,362	134,471
Lease termination costs	-	178,661
	<u>\$ 2,743,847</u>	<u>\$ 2,846,839</u>

SUPPLEMENTAL INFORMATION

TEAMSTERS SECURITY FUND FOR
SOUTHERN NEVADA LOCAL 14
EIN: 88-0087294
PLAN NO: 501
DECEMBER 31, 2024

In response to Schedule H, Line 4i - Schedule of Assets (Held at Year End)

Column (a)	Columns (b) & (c)	Column (d)	Column (e)
Face	Description	Cost	Fair Value
	<u>Limited Partnership</u>		
1,215	PGIM Real Estate U.S. Debt Fund, LP	\$ 1,757,661	\$ 1,923,955
		<u>1,757,661</u>	<u>1,923,955</u>
	<u>Mutual Funds</u>		
393,144	Dodge & Cox Income Fund	4,911,491	4,867,119
27,147	Fidelity Total Market Index Fund	3,045,319	4,377,881
340,436	Neuberger Berman Strategic Fund	3,323,622	3,360,107
316,288	Pimco Income Fund	3,390,165	3,327,345
370,201	Vanguard Short-Term Bond Index Fund	3,706,073	3,750,139
540,036	JPMIT Core Bond Fund	<u>4,784,637</u>	<u>4,752,314</u>
		<u>23,161,307</u>	<u>24,434,905</u>
	<u>Cash and Equivalents</u>		
667,874	Allspring Treas Plus MM FD	<u>667,874</u>	<u>667,874</u>
		<u>667,874</u>	<u>667,874</u>
	Total Investments	<u>\$ 25,586,842</u>	<u>\$ 27,026,734</u>

TEAMSTERS SECURITY FUND FOR
SOUTHERN NEVADA LOCAL 14
EIN: 88-0087294
PLAN NO: 501
FOR THE YEAR ENDED DECEMBER 31, 2024

In response to Schedule H, Line 4j - Schedule of Reportable Transactions

Column (a)	Column (b)	Column (c)	Column (d)	Column (e)	Column (f)	Column (g)	Column (h)	Column (i)
Face	Description	Purchase Price	Selling Price	Lease Rental	Expense Incurred with Transaction	Cost of Asset	Transaction Date Current Value	Net Gain or (Loss)
46,017,573	Allspring Tres Plus MM FD	\$ 46,017,573	\$ -	\$ -	\$ -	\$ -	\$ 46,017,573	\$ -
46,989,912	Allspring Tres Plus MM FD	\$ -	\$ 46,989,912	\$ -	\$ -	\$ 46,989,912	\$ 46,989,912	\$ -
417,067	Dodge & Cox Income Fund	\$ 5,210,385	\$ -	\$ -	\$ -	\$ -	\$ 5,210,385	\$ -
23,923	Dodge & Cox Income Fund	\$ -	\$ 300,000	\$ -	\$ -	\$ 298,893	\$ 300,000	\$ 1,107
497,018	Vanguard Short-Term Bond Index Fund	\$ -	\$ 5,000,000	\$ -	\$ -	\$ 4,973,775	\$ 5,000,000	\$ 26,225
13,287	Vanguard Short-Term Bond Index Fund	\$ 134,351	\$ -	\$ -	\$ -	\$ -	\$ 134,351	\$ -
511,774	JP Morgan Core Bond Fund	\$ -	\$ 5,214,685	\$ -	\$ -	\$ 5,299,967	\$ 5,214,685	\$ (85,283)
17,077	JP Morgan Core Bond Fund	\$ 174,161	\$ -	\$ -	\$ -		\$ 174,161	\$ -

TEAMSTERS SECURITY FUND FOR
SOUTHERN NEVADA LOCAL 14
EIN: 88-0087294
PLAN NO: 501
DECEMBER 31, 2024

In response to Schedule H, Line 4i - Schedule of Assets (Held at Year End)

Column (a)	Columns (b) & (c)	Column (d)	Column (e)
Face	Description	Cost	Fair Value
	<u>Limited Partnership</u>		
1,215	PGIM Real Estate U.S. Debt Fund, LP	\$ 1,757,661	\$ 1,923,955
		<u>1,757,661</u>	<u>1,923,955</u>
	<u>Mutual Funds</u>		
393,144	Dodge & Cox Income Fund	4,911,491	4,867,119
27,147	Fidelity Total Market Index Fund	3,045,319	4,377,881
340,436	Neuberger Berman Strategic Fund	3,323,622	3,360,107
316,288	Pimco Income Fund	3,390,165	3,327,345
370,201	Vanguard Short-Term Bond Index Fund	3,706,073	3,750,139
540,036	JPMIT Core Bond Fund	<u>4,784,637</u>	<u>4,752,314</u>
		<u>23,161,307</u>	<u>24,434,905</u>
	<u>Cash and Equivalents</u>		
667,874	Allspring Treas Plus MM FD	<u>667,874</u>	<u>667,874</u>
		<u>667,874</u>	<u>667,874</u>
	Total Investments	<u>\$ 25,586,842</u>	<u>\$ 27,026,734</u>

TEAMSTERS SECURITY FUND FOR
SOUTHERN NEVADA LOCAL 14
EIN: 88-0087294
PLAN NO: 501
FOR THE YEAR ENDED DECEMBER 31, 2024

In response to Schedule H, Line 4j - Schedule of Reportable Transactions

Column (a)	Column (b)	Column (c)	Column (d)	Column (e)	Column (f)	Column (g)	Column (h)	Column (i)
Face	Description	Purchase Price	Selling Price	Lease Rental	Expense Incurred with Transaction	Cost of Asset	Transaction Date Current Value	Net Gain or (Loss)
46,017,573	Allspring Tres Plus MM FD	\$ 46,017,573	\$ -	\$ -	\$ -	\$ -	\$ 46,017,573	\$ -
46,989,912	Allspring Tres Plus MM FD	\$ -	\$ 46,989,912	\$ -	\$ -	\$ 46,989,912	\$ 46,989,912	\$ -
417,067	Dodge & Cox Income Fund	\$ 5,210,385	\$ -	\$ -	\$ -	\$ -	\$ 5,210,385	\$ -
23,923	Dodge & Cox Income Fund	\$ -	\$ 300,000	\$ -	\$ -	\$ 298,893	\$ 300,000	\$ 1,107
497,018	Vanguard Short-Term Bond Index Fund	\$ -	\$ 5,000,000	\$ -	\$ -	\$ 4,973,775	\$ 5,000,000	\$ 26,225
13,287	Vanguard Short-Term Bond Index Fund	\$ 134,351	\$ -	\$ -	\$ -	\$ -	\$ 134,351	\$ -
511,774	JP Morgan Core Bond Fund	\$ -	\$ 5,214,685	\$ -	\$ -	\$ 5,299,967	\$ 5,214,685	\$ (85,283)
17,077	JP Morgan Core Bond Fund	\$ 174,161	\$ -	\$ -	\$ -		\$ 174,161	\$ -