

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

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

- A This return/report is for: [X] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension... E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here... []

Part II Basic Plan Information—enter all requested information

1a Name of plan: N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND
1b Three-digit plan number (PN): 001
1c Effective date of plan: 01/05/1982
2a Plan sponsor's name (employer, if for a single-employer plan): BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND
2b Employer Identification Number (EIN): 04-2776873
2c Plan Sponsor's telephone number: 978-694-1000
2d Business code (see instructions): 236200

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

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

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include Joseph Byrne (10/07/2025) and Thomas S. Gunning (10/06/2025).

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	23926
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)	10943
	6a(2)	10412
	6b	2025
	6c	10499
	6d	22936
	6e	788
	6f	23724
	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	503

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
1B 1C

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

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 MB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	<small>OMB No. 1210-0110</small> 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

▶ **Round off amounts to nearest dollar.**
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND</u>	D Employer Identification Number (EIN) <u>04-2776873</u>

E Type of plan: (1) Multiemployer Defined Benefit (2) Money Purchase (see instructions)

1a Enter the valuation date: Month 01 Day 01 Year 2024

b Assets	
(1) Current value of assets	1b(1) <u>3616716414</u>
(2) Actuarial value of assets for funding standard account	1b(2) <u>3775473394</u>
c (1) Accrued liability for plan using immediate gain methods	1c(1) <u>3513808258</u>
(2) Information for plans using spread gain methods:	
(a) Unfunded liability for methods with bases	1c(2)(a)
(b) Accrued liability under entry age normal method	1c(2)(b)
(c) Normal cost under entry age normal method	1c(2)(c)
(3) Accrued liability under unit credit cost method	1c(3) <u>3661373437</u>
d Information on current liabilities of the plan:	
(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1)
(2) "RPA '94" information:	
(a) Current liability	1d(2)(a) <u>4088291404</u>
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b) <u>119774563</u>
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c) <u>147123031</u>
(3) Expected plan disbursements for the plan year	1d(3) <u>152823031</u>

Statement by Enrolled Actuary
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE Signature of actuary <u>KATHLEEN A. RILEY, FSA, MAAA, EA</u> Type or print name of actuary <u>SEGAL</u> Firm name <u>116 HUNTINGTON AVENUE</u> <u>SUITE 901</u> <u>BOSTON, MA 02116-5744</u> Address of the firm	<u>10/01/2025</u> Date <u>23-04134</u> Most recent enrollment number <u>617-424-7300</u> Telephone number (including area code)
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	2a	3616716414
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	2760	590321113
(2) For terminated vested participants	12430	927298666
(3) For active participants:		
(a) Non-vested benefits		913504851
(b) Vested benefits		1657166774
(c) Total active	8892	2570671625
(4) Total	24082	4088291404
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	%

3 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	
07/15/2024	112316701					
			Totals ▶	3(b)	112316701	
(d) Total withdrawal liability amounts included in line 3(b) total					3(c)	0
					3(d)	0

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)).....	4a	103.1 %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	4b	N
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d If the plan is in critical status or critical and declining status, does line 1(c) reflect any benefit reductions for the first time (see instructions)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	4e	
f If the plan is in critical status or critical and declining status, and is: • Projected to emerge from critical status within 30 years, enter the plan year in which it is projected to emerge; • Projected to become insolvent within 30 years, enter the plan year in which insolvency is expected and check here <input type="checkbox"/> • Neither projected to emerge from critical status nor become insolvent within 30 years, enter "9999."	4f	

5 Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

a <input type="checkbox"/> Attained age normal	b <input checked="" type="checkbox"/> Entry age normal	c <input type="checkbox"/> Accrued benefit (unit credit)	d <input type="checkbox"/> Aggregate
e <input type="checkbox"/> Frozen initial liability	f <input type="checkbox"/> Individual level premium	g <input type="checkbox"/> Individual aggregate	h <input type="checkbox"/> Shortfall
i <input type="checkbox"/> Other (specify):			
j If box h is checked, enter period of use of shortfall method	5j		
k Has a change been made in funding method for this plan year?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
m If line k is "Yes," and line l is "No," enter the date (MM/DD/YYYY) of the ruling letter (individual or class) approving the change in funding method	5m		

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability.....	6a	3.29 %
	Pre-retirement	Post-retirement
b Rates specified in insurance or annuity contracts.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
c Mortality table code for valuation purposes:		
(1) Males	6c(1)	5MP+1
(2) Females	6c(2)	5FP+1
d Valuation liability interest rate	6d	7.25 %
e Salary scale	6e	% <input checked="" type="checkbox"/> N/A
f Withdrawal liability interest rate:		
(1) Type of interest rate	6f(1)	<input type="checkbox"/> Single rate <input type="checkbox"/> ERISA 4044 <input checked="" type="checkbox"/> Other <input type="checkbox"/> N/A
(2) If "Single rate" is checked in (1), enter applicable single rate	6f(2)	%
g Estimated investment return on actuarial value of assets for year ending on the valuation date	6g	8.5 %
h Estimated investment return on current value of assets for year ending on the valuation date	6h	5.3 %
i Expense load included in normal cost reported in line 9b	6i	<input type="checkbox"/> N/A
(1) If expense load is described as a percentage of normal cost, enter the assumed percentage.....	6i(1)	%
(2) If expense load is a dollar amount that varies from year to year, enter the dollar amount included in line 9b.....	6i(2)	5700000
(3) If neither (1) nor (2) describes the expense load, check the box	6i(3)	<input type="checkbox"/>

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit

8 Miscellaneous information:

a If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM/DD/YYYY) of the ruling letter granting the approval	8a	
b Demographic, benefit, and contribution information		
(1) Is the plan required to provide a projection of expected benefit payments? (See instructions) If "Yes," see instructions for required attachment.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
(2) Is the plan required to provide a Schedule of Active Participant Data? (See instructions).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
(3) Is the plan required to provide a projection of employer contributions and withdrawal liability payments? (See instructions) If "Yes," attach a schedule.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
d If line c is "Yes," provide the following additional information:		
(1) Was an extension granted automatic approval under section 431(d)(1) of the Code?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended ..	8d(2)	
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	8d(4)	
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension	8d(5)	
(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e If box 5h is checked or the plan received an amortization extension for this plan year under Code section 431(d), enter the difference between the amount necessary to satisfy the plan's minimum funding standard for this plan year and the amount that would have been necessary without using the shortfall method or extending the amortization period(s).	8e	

9 Funding standard account statement for this plan year:

Charges to funding standard account:

a Prior year funding deficiency, if any	9a	0
b Employer's normal cost for plan year as of valuation date.....	9b	96566286

c Amortization charges as of valuation date:		Outstanding balance	
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	0	0
(2) Funding waivers	9c(2)		
(3) Certain bases for which the amortization period has been extended.....	9c(3)		
d Interest as applicable on lines 9a, 9b, and 9c.....	9d		7001056
e Total charges. Add lines 9a through 9d.....	9e		103567342
Credits to funding standard account:			
f Prior year credit balance, if any.....	9f		427785967
g Employer contributions. Total from column (b) of line 3.....	9g		112316701
		Outstanding balance	
h Amortization credits as of valuation date.....	9h	0	0
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i		34746673
j Full funding limitation (FFL) and credits:			
(1) ERISA FFL (accrued liability FFL).....	9j(1)	126122487	
(2) "RPA '94" override (90% current liability FFL)	9j(2)	0	
(3) FFL credit	9j(3)		0
k (1) Waived funding deficiency	9k(1)		0
(2) Other credits	9k(2)		0
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)	9l		574849341
m Credit balance: If line 9l is greater than line 9e, enter the difference	9m		471281999
n Funding deficiency: If line 9e is greater than line 9l, enter the difference	9n		
o Current year's accumulated reconciliation account:			
(1) Due to waived funding deficiency accumulated prior to the current plan year.....	9o(1)		0
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:			
(a) Reconciliation outstanding balance as of valuation date	9o(2)(a)		0
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)).....	9o(2)(b)		0
(3) Total as of valuation date.....	9o(3)		0
10 Contribution necessary to avoid an accumulated funding deficiency. (see instructions.).....	10		
11 Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions			

Yes No

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 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 N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND	D Employer Identification Number (EIN) 04-2776873	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

36 SOUTH INVEST MGRS (CAYMAN) LTD **PO BOX 309 UGLAND HOUSE**
GRAND CAYMAN, CAYMAN ISLANDS KY1 1104 KY

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

ABS GLOBAL INVESTMENTS

13-4205457

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

ACTIS ENERGY 4

98-1304256

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

ACTIS ENERGY 5

98-1529176

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

AFL-CIO HOUSING INVESTMENT TRUST

52-6220193

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

ALTARIS CAPITAL PARTNERS LLC

20-5988933

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

AMERICAN REALTY ADVISORS LLC

33-0123114

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

ARES ENERGY INVESTORS FUND V LP

35-2527651

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

ATLAS VENTURE LIFE SCIENCE ADVISORS

300 TECHNOLOGY SQUARE
8TH FLOOR
CAMBRIDGE, MA 02139

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

AZTEC FINANCIAL SERVICES (GUERNSEY)

PO BOX 656 EAST WING TRAFALGAR COURT
LES BANQUES, ST PETER PORT GY13PP GG

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

BASALT INFRASTRUCTURE PARTNERS II

98-1338721

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

BASALT INFRASTRUCTURE PARTNERS III

98-1522136

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

BASALT INFRASTRUCTURE PARTNERS IV

98-1669601

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

BLACKROCK FINANCIAL MANAGEMENT INC

13-3806691

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

BLACKSTONE INFRASTRUCTURE ADVISORS 345 PARK AVENUE
NEW YORK, NY 10154

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

BRIGADE CAPITAL MANAGEMENT LP

26-0240191

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

CAI MANAGER LP 39 FORREST STREET
SUITE 201
MILL VALLEY, CA 94941

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

CCP III ADVISORY LTD 28/F CITIC TOWER 1 TIM MEI AVENUE
CENTRAL, HONG KONG SAR HK

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

CHARLESBANK CAPITAL PARTNERS LLC

04-3419769

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

CHEQUERS PARTENAIRES SA 5 RUE FRANCOIS 1ER
PARIS, FRANCE 75008 FR

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

CONSTITUTION CAPITAL EQUITY PARTNER

74-3246212

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

CZECH ASSET MANAGEMENT LP

45-3236373

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

DBAG FUND VI GP (GUERNSEY) LP

SECOND FLOOR LA PLAIDERIE CHAMBERS
LA PLAIDERIE, ST PETER PORT GY11WG GG

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

DBAG FUND VII GP S.A.R.1

8 RUE LOU HEMMER SENNINGERBERG
GRAND-DUCHE DE LUXEMBO, LUXEMBOURG 1748 LU

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

DIMENSIONAL FUND ADVISORS LP

30-0447847

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

EIF UNITED STATES POWER IV LLC

1800 AVENUE OF THE STARS
SUITE 1400
LOS ANGELES, CA 90067

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

ENERGY VENTURES IV LP

98-0701954

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

ENTRUST GLOBAL PARTNERS OFFSHORE LP

90-0644478

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

ESP 2006 GENERAL PARTNERS LP

1 GEORGE STREET
EDINBURGH, UNITED KINGDOM EH22LL GB

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

FIRST EAGLE INVESTMENT MGMT LLC

57-1156902

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

FLAGSHIP PIONEERING INC

55 CAMBRIDGE PARKWAY
SUITE 800E
CAMBRIDGE, MA 02142

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

GAMUT CAPITAL MANAGEMENT LP

47-4084591

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

GAUGE CAPITAL LLC

46-3013665

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

GEM REALTY MANAGERS V LP

80-0881501

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

GLOBAL INFRASTRUCTURE MGMT LLC

1345 AVENUE OF THE AMERICAS
30TH FLOOR
NEW YORK, NY 10105

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

GOLUB CAPITAL BDC 4 INC

88-1608711

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

GQG PARTNERS

450 EAST LAS OLAS BLVD
SUITE 750
FORT LAUDERDALE, FL 33301

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

GRAIN MANAGEMENT LLC

27-2066237

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

GREENBRIAR EQUITY GROUP LP

13-4089194

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

GTIS PARTNERS LP

787 7TH AVENUE
50TH FLOOR
NEW YORK, NY 10019

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

H.I.G. CAPITAL LLC

65-0863927

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

HARBOURVEST VIII BUYOUT ASSOC LP

51-0578242

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

JMI MANAGEMENT LP

20-2772092

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

K1 INVESTMENT MANAGEMENT LLC

27-4741827

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

KEROGEN GENERAL PARTNER II LTD

190 ELGIN AVENUE
GEORGE TOWN, GRAND CAYMAN KY1 9008 KY

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

KPS CAPITAL PARTNERS LP

ONE VANDERBILT AVENUE
52ND FLOOR
NEW YORK, NY 10017

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

MBK MANAGEMENT INC

SUITE 1707-08 ONE EXCHANGE SQUARE 8 CONNAUGHT PLACE
CENTRAL, HONG KONG 999077 HK

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

NEWTOWER TRUST COMPANY

30-0872552

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

OAKLEY CAPITAL V S.A.R.1

8 RUE LOU HEMMER SENNINGERBERG
GRAND-DUCHE DE LUXEMBO, LUXEMBOURG 1748 LU

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

OAKTREE CAPITAL MANAGEMENT LP

26-0189082

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

ONCAP MANAGEMENT PARTNERS LP

161 BAY STREET SUITE 4900
TORONTO, ONTARIO M5J 2S1 CA

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

ONE RIVER ASSET MANAGEMENT LLC

46-2311563

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

ORION CAPITAL MANAGERS LLP

63 BROOK STREET
LONDON, UNITED KINGDOM W1K 4HS GB

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

ORION MINE FINANCE MANAGEMENT LP

251 LITTLE FALLS DRIVE
WILMINGTON, DE 19808

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

PAG ASIA CAPITAL GP I LTD

103 SOUTH CHURCH STREET 2ND FLOOR
HARBOUR PLACE, GRAND CAYMAN KY1 1106 KY

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

PAG ASIA CAPITAL GP II LTD

98-1273928

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

PAG ASIA CAPITAL GP III LTD

98-1446205

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

PAINE SCHWARTZ PARTNERS LLC

475 FIFTH AVENUE
17TH FLOOR
NEW YORK, NY 10017

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

PAINE SCHWARTZ PTNRS FUND V MGMT

475 FIFTH AVENUE
17TH FLOOR
NEW YORK, NY 10017

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

PANTHEON VENTURES (US) LP

555 CALIFORNIA STREET
SUITE 3450
SAN FRANCISCO, CA 94104

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

PANTHEON VENTURES INC
555 CALIFORNIA STREET
SUITE 3450
SAN FRANCISCO, CA 94104

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

PATRIA-PRIVATE EQUITY GP VI LTD

98-1411655

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

PBPE GP IV LTD

98-1008704

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

PBPE GP V LTD

98-1179780

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

REF IV ASSOCIATES LP
630 5TH AVE
SUITE 400
NEW YORK, NY 10111

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

RELATED REAL ESTATE FUND III LP

83-4237103

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

RELIANCE TRUST COMPANY

58-1428634

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

RICHMOND CAPITAL MANAGEMENT INC

26-3436991

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

RIDGEWOOD ENERGY CORPORATION

76-0036505

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

RIVERSIDE PARTNERS V CF LP

699 BOYLSTON STREET
14TH FLOOR
BOSTON, MA 02116

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

RMCF III ASSOCIATES LLC

630 5TH AVE
SUITE 400
NEW YORK, NY 10111

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

SEIDLER KUTSENDA MGMT COMPANY LLC

75-3143904

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

SENTINEL CAPITAL PARTNERS LLC

ONE VANDERBILT AVENUE
53RD FLOOR
NEW YORK, NY 10017

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

SOLAMERE CAPITAL AF III LP

82-1686590

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

SOLAMERE CAPITAL AF III-A LP

83-2557195

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

SOLAMERE CAPITAL AF IV-A LP

86-1271961

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

SOUTHERN CROSS GROUP MANAGEMENT LP

98-0518602

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

STELLEX MANAGEMENT II LP
900 THIRD AVENUE
25TH FLOOR
NEW YORK, NY 10022

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

STG PARTNERS LLC
1300 EL CAMINO REAL
SUITE 300
MENLO PARK, CA 94025

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

TA XII-B EU AIV LP

98-1296319

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

TA XII-B LP

30-0864929

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

TA XIII-B LP

98-1477051

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

TA XIV-B LP

98-1593568

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

THIRD ROCK VENTURES III LP

38-3898567

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

THIRD ROCK VENTURES IV LP

81-4370882

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

THIRD ROCK VENTURES V LP

84-1868726

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

THIRD ROCK VENTURES VI LP

88-2485899

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

TOWERBROOK INVESTORS IV LP (ONSHORE)

98-1075105

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

TRILANTIC CAPITAL MANAGEMENT LP

26-4600829

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

ULLICO INVESTMENT ADVISORS INC

52-6435649

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

VISTA EQUITY PARTNERS FUND IV GP LLC

4 EMBARCADERO CENTER
20TH FLOOR
SAN FRANCISCO, CA 94111

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

VITRUVIAN PARTNERS LLP

105 WIGMORE STREET
LONDON, UNITED KINGDOM W1U 1QY GB

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

WESTPORT CAPITAL PARTNERS LLC

20-3834766

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

WHITE DEER MANAGEMENT LLC

700 LOUISIANA STREET
SUITE 4770
HOUSTON, TX 77002

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

WYNNCHURCH PARTNERS VI GP LP

6250 N RIVER ROAD
SUITE 10-100
ROSEMONT, IL 60018

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

RELATED REAL ESTATE FUND IV LP

99-0494266

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

PACIFIC INVESTMENT MGMT CO LLC

650 NEWPORT CENTER DRIVE
NEWPORT BEACH, CA 92660

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

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

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

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

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

MEKETA INVESTMENT GROUP INC.

04-2659023

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	1049964	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WASHINGTON CAPITAL MANAGEMENT INC.

91-1042342

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	689421	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ARTISAN PARTNERS LMTD PARTNERSHIP

30-0551775

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 52 68	NONE	562230	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

NASC PENSION FUND CCA

51-6040899

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 50	COMMON BOARD	507642	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ACADIAN ASSET MANAGEMENT LLC

04-2929221

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	367007	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LOOMIS SAYLES & COMPANY

04-3200030

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	303397	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

STATE STREET BANK & TRUST CO.

04-1867445

(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 28 51 52 62 99	NONE	262757	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

BNY MELLON INVESTMENT ADVISER INC.

13-5673135

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 52 68	NONE	245294	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

RICE HALL JAMES & ASSOC LLC

43-1992528

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 52	NONE	231456	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

DODGE & COX INVESTMENT MANAGERS

94-1441976

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 68	NONE	221180	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

J.P. MORGAN CHASE BANK NATL ASSOC.

13-4994650

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	188418	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

THE SEGAL COMPANY (EASTERN STATES)

13-1835864

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 50	NONE	167690	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LENDINGCLUB BANK NA

85-4191886

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50 64	NONE	163670	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WELLINGTON TRUST COMPANY NA

04-2755549

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	153203	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VICTORY CAPITAL MANAGEMENT

13-2700161

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 68	NONE	149488	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

COVE STREET CAPITAL LLC

27-5376591

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	142526	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KRAKOW SOURIS & LANDRY LLC

04-3363718

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	95000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

OREILLY GROSSO GROSS & JONES PC

04-3318596

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	94250	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SCHULTHEIS & PANETTIERI LLP

13-1577780

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	88000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WITHUMSMITH+BROWN, P.C.

22-2027092

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	83350	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BLACKROCK INSTL TRUST COMPANY N.A.

94-3112180

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 24 28 50 51 52 68	NONE	74305	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

RHUMBLINE ADVISERS LMTD PARTNERSHIP

04-3118582

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	65038	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

THE JOURNEYMAN PRESS

46-5227450

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	17551	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PROXYVOTE PLUS HOLDINGS INC.

20-0509976

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	13500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

INVESCO TRUST COMPANY

46-3793325

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 28 51 52 67 68	NONE	9927	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

SEGAL SELECT INSURANCE SERVICES INC

46-0619194

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	37690	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
SEGAL SELECT INSURANCE SVCS INC	53	21793
(d) Enter name and EIN (address) of source of indirect compensation CHUBB 13-1963496	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INSURANCE BROKERAGE COMMISSIONS AND FEES	
(a) Enter service provider name as it appears on line 2 SEGAL SELECT INSURANCE SVCS INC	(b) Service Codes (see instructions) 53	(c) Enter amount of indirect compensation 8074
(d) Enter name and EIN (address) of source of indirect compensation ENCORE FIDUCIARY 45-3957469	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INSURANCE BROKERAGE COMMISSIONS AND FEES	
(a) Enter service provider name as it appears on line 2 SEGAL SELECT INSURANCE SVCS INC	(b) Service Codes (see instructions) 53	(c) Enter amount of indirect compensation 4344
(d) Enter name and EIN (address) of source of indirect compensation ULLICO / MARKEL 13-2988846	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INSURANCE BROKERAGE COMMISSIONS AND FEES	

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
SEGAL SELECT INSURANCE SVCS INC	53	3479
(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.	
RLI INSURANCE 37-0915434	INSURANCE BROKERAGE COMMISSIONS AND FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

a Name:	A. DONALD MORGAN, FSA, MAAA, EA	b EIN:	13-1835864
c Position:	ENROLLED ACTUARY		
d Address:	116 HUNTINGTON AVENUE SUITE 901 BOSTON, MA 02116-5744	e Telephone:	617-424-7300

Explanation: A. DONALD MORGAN RETIRED DURING THE YEAR. THE CHANGE IN ENROLLED ACTUARY IS DUE TO A REASSIGNMENT WITHIN THE ACTUARIAL FIRM.

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan 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 <hr/> 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 <u>N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND</u>	B Three-digit plan number (PN)	<u>001</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND</u>	D Employer Identification Number (EIN) <u>04-2776873</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>0-5 YEAR US TIPS FUND</u>	b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY NA</u>	
c EIN-PN <u>46-3843139-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>87311377</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>1-3 YR GOVT/CREDIT BOND INDEX FUND</u>	b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY NA</u>	
c EIN-PN <u>27-5012611-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>46755873</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>COMMINGLED PENSION TRUST FUND</u>	b Name of sponsor of entity listed in (a): <u>JPMORGAN CHASE BANK NA</u>	
c EIN-PN <u>13-6038770-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>18972184</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>EAFE EQUITY INDEX FUND</u>	b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY NA</u>	
c EIN-PN <u>94-6596958-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>3564427</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>EQUITY INDEX FUND</u>	b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY NA</u>	
c EIN-PN <u>94-6052285-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>97205363</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>GQG PTNRS EMERGING MKTS EQUITY CIT</u>	b Name of sponsor of entity listed in (a): <u>RELIANCE TRUST COMPANY</u>	
c EIN-PN <u>82-6258259-012</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>26101172</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>HARBOURVEST PTNRS VIII-BUYOUT FD LP</u>	b Name of sponsor of entity listed in (a): <u>HARBOURVEST PARTNERS LLC</u>	
c EIN-PN <u>34-2063501-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>81431</u>

a Name of MTIA, CCT, PSA, or 103-12 IE: HARBOURVEST PTNRS VIII-VENTURE FUND		
b Name of sponsor of entity listed in (a): HARBOURVEST PARTNERS LLC		
c EIN-PN 34-2063502-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3018325
a Name of MTIA, CCT, PSA, or 103-12 IE: HIPEP V-CAYMAN US DOLLAR PTNRSHF FD		
b Name of sponsor of entity listed in (a): HARBOURVEST PARTNERS LLC		
c EIN-PN 98-0468020-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0
a Name of MTIA, CCT, PSA, or 103-12 IE: HRBRVST VIII-CAYMAN MEZ & DIST DEBT		
b Name of sponsor of entity listed in (a): HARBOURVEST PARTNERS LLC		
c EIN-PN 98-0494212-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 81473
a Name of MTIA, CCT, PSA, or 103-12 IE: HRBRVST VIII-MEZZ & DISTRESSED DEBT		
b Name of sponsor of entity listed in (a): HARBOURVEST PARTNERS LLC		
c EIN-PN 34-2063515-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 52891
a Name of MTIA, CCT, PSA, or 103-12 IE: MSCI EMERGING MARKETS FREE FUND		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 33-1030441-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 5539871
a Name of MTIA, CCT, PSA, or 103-12 IE: MSCI EQUITY INDEX FUND - RUSSIA		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 86-1583137-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 36
a Name of MTIA, CCT, PSA, or 103-12 IE: NCS GROUP TRUST - GLOBAL FUND		
b Name of sponsor of entity listed in (a): BNY MELLON INVESTMENT MANAGEMENT CAYMAN LTD		
c EIN-PN 76-6192146-003	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 37902378
a Name of MTIA, CCT, PSA, or 103-12 IE: NEWTOWER TRUST COMPANY MEPT		
b Name of sponsor of entity listed in (a): NEWTOWER TRUST COMPANY		
c EIN-PN 52-6218800-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11814240
a Name of MTIA, CCT, PSA, or 103-12 IE: PROLOAN BOND FUND LLC		
b Name of sponsor of entity listed in (a): PROLOAN BOND FUND LLC		
c EIN-PN 26-3436991-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 18797521
a Name of MTIA, CCT, PSA, or 103-12 IE: RHUMBLINE QSI INDEX LLC		
b Name of sponsor of entity listed in (a): RHUMBLINE ADVISERS CORP		
c EIN-PN 26-0137355-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 175271501

a Name of MTIA, CCT, PSA, or 103-12 IE: RUSSELL 2000 INDEX FUND		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 94-3273839-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1232057
a Name of MTIA, CCT, PSA, or 103-12 IE: S&P GLOB LGMIDCAP NAT RES IDX NL FD		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 90-0337987-287	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1113100
a Name of MTIA, CCT, PSA, or 103-12 IE: SENIOR FLOATING RATE FUND LLC		
b Name of sponsor of entity listed in (a): LOOMIS SAYLES AND COMPANY LP		
c EIN-PN 82-0542784-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 74742292
a Name of MTIA, CCT, PSA, or 103-12 IE: SHORT-TERM INVESTMENT FUND		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 94-6450621-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 41190
a Name of MTIA, CCT, PSA, or 103-12 IE: UBC RUSSELL 3000 INDEX TRUST		
b Name of sponsor of entity listed in (a): INVESCO TRUST COMPANY		
c EIN-PN 20-2583973-306	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 182815539
a Name of MTIA, CCT, PSA, or 103-12 IE: ULLICO INFRASTRUCTURE TAXABLE FUND		
b Name of sponsor of entity listed in (a): ULLICO INVESTMENT ADVISORS INC.		
c EIN-PN 45-5209095-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 33221332
a Name of MTIA, CCT, PSA, or 103-12 IE: US DEBT INDEX FUND		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 94-6589507-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 34932442
a Name of MTIA, CCT, PSA, or 103-12 IE: US TIPS FUND		
b Name of sponsor of entity listed in (a): BLACKROCK INSTITUTIONAL TRUST COMPANY NA		
c EIN-PN 94-3410125-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 85743847
a Name of MTIA, CCT, PSA, or 103-12 IE: WTC-CTF EMERGING LOCAL DEBT		
b Name of sponsor of entity listed in (a): WELLINGTON TRUST COMPANY NA		
c EIN-PN 27-2594633-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 33344435
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 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 N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND	D Employer Identification Number (EIN) 04-2776873

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	4028137	3382310
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	30945567	16768458
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	135543765	97385128
(2) U.S. Government securities	1c(2)	156127626	158357483
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	7756885	11395548
(B) All other	1c(3)(B)	98462032	102416926
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	3192572	4547610
(B) Common	1c(4)(B)	338239625	377046577
(5) Partnership/joint venture interests	1c(5)	1645396655	1663234057
(6) Real estate (other than employer real property)	1c(6)	179884823	139982248
(7) Loans (other than to participants)	1c(7)	12799891	22461596
(8) Participant loans	1c(8)	34011307	34756674
(9) Value of interest in common/collective trusts	1c(9)	522215905	636487153
(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)	372116961	343169144
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	149924182	132835325
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	28257672	25590588

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	19223624	27555265
f Total assets (add all amounts in lines 1a through 1e).....	1f	3738127229	3797372090
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h	5842693	3313174
i Acquisition indebtedness.....	1i	59169237	37263216
j Other liabilities.....	1j	56398885	58237710
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	121410815	98814100
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	3616716414	3698557990

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)	112316701	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)	820842	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		113137543
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	2982931	
(B) U.S. Government securities.....	2b(1)(B)	3298288	
(C) Corporate debt instruments.....	2b(1)(C)	3251906	
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	5908049	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		15441174
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)	4073807	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	5578370	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		9652177
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	494438284	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	680316714	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		-185878430
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)	6837018	
(B) Other.....	2b(5)(B)	230647062	
(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)		50666036
(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)		37049527
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-1013966
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		276538141

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	177359125	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		177359125
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		3861136
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	88000	
(5) Investment advisory and investment management fees	2i(5)	4951434	
(6) Bank or trust company trustee/custodial fees	2i(6)	426427	
(7) Actuarial fees	2i(7)	167690	
(8) Legal fees	2i(8)	189250	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	7653503	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		13476304
j Total expenses. Add all expense amounts in column (b) and enter total	2j		194696565

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		81841576
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: SCHULTHEIS & PANETTIERI, LLP

(2) EIN: 13-1577780

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		10000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	X		1929705394
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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 559295.

SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 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 N. ATLANTIC STATES CARP. GUARANTEED ANNUITY FUND	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 BOT OF THE NORTH ATLANTIC STATES CARPENTERS GUARANTEED ANNUITY FUND	D Employer Identification Number (EIN) 04-2776873	

Part I	Distributions
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All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): _____		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	799

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)
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4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... Increase Decrease Both No

Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer **NEW ENGLAND FINISH SYSTEMS**

b EIN **68-0641275**

c Dollar amount contributed by employer **4291651**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **T J MCCARTNEY INC**

b EIN **02-0330467**

c Dollar amount contributed by employer **3838224**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **CENTURY DRYWALL INC**

b EIN **05-0460679**

c Dollar amount contributed by employer **3622396**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **08** Day **31** Year **2027**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **SWEENEY DRYWALL FINISHES**

b EIN **04-3161586**

c Dollar amount contributed by employer **2780046**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **S & F CONCRETE COMPANY**

b EIN **04-2439090**

c Dollar amount contributed by employer **2753759**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **RIGGS CONTRACTING INC**

b EIN **26-0358105**

c Dollar amount contributed by employer **2705415**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer **TURNER CONSTRUCTION COMPANY**

b EIN **13-1401980** **c** Dollar amount contributed by employer **2670777**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **MARGUERITE CONCRETE CONTRACTOR**

b EIN **04-3035873** **c** Dollar amount contributed by employer **2215760**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **COLONIAL SYSTEMS INC**

b EIN **04-3152864** **c** Dollar amount contributed by employer **1925496**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **CENTRAL CEILINGS INC**

b EIN **04-2302236** **c** Dollar amount contributed by employer **1912046**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input checked="" type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment).....	14a	0
b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14b	0
c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14c	0

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....	16b	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
 Public Equity: 25.00 % Private Equity: 25.00 % Investment-Grade Debt and Interest Rate Hedging Assets: 13.00 %
 High-Yield Debt: 7.00 % Real Assets: 25.00 % Cash or Cash Equivalents: 1.00 % Other: 4.00 %

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation: _____

Part VII IRS Compliance Questions

21a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

Design-based safe harbor method

"Prior year" ADP test

"Current year" ADP test

N/A

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

Attachments Unavailable

Attachments for the selected filing cannot be publicly disclosed over the website as the Department of Labor determined that one or more attachments may contain sensitive personally identifiable information. Please contact the Department of Labor EBSA Public Disclosure Office as noted below in order to request a redacted copy of the document you need.

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