

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110  
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A This return/report is for: [X] a multiemployer plan [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [ ] a single-employer plan [ ] a DFE (specify) \_\_\_\_
B This return/report is: [ ] the first return/report [ ] the final return/report [ ] an amended return/report [ ] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. . . . . [X]
D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program [ ] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan: NEW ENGLAND HEALTH CARE EMPLOYEES UNION DISTRICT 1199 AND THE CT NURSING HOMES TRAINING AND UPGRADING FUND
1b Three-digit plan number (PN) ▶ 501
1c Effective date of plan 12/18/1985
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BRD OF TRUSTEES-NEW ENGLAND HLTH CARE & CT NURSG HOMES TRNG & UP MES TRNG & UPGRADING FUND 77 HUYSHOPE AVENUE HARTFORD, CT 06106-7000
2b Employer Identification Number (EIN) 06-1163056
2c Plan Sponsor's telephone number 860-251-6060
2d Business code (see instructions) 623000

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 entries for plan administrator (JESSE MARTIN), employer/plan sponsor (SEAN KENNEDY), and DFE.

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

Form 5500 (2024) v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	5405
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	5405
	<b>6a(2)</b>	7062
	<b>6b</b>	
	<b>6c</b>	
	<b>6d</b>	7062
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	41

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

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
4J

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> 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)

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

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

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

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

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

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

Receipt Confirmation Code \_\_\_\_\_

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

<b>A</b> Name of plan  <b>NEW ENGLAND HEALTH CARE EMPLOYEES UNION DISTRICT 1199 AND THE CT NURSING HOMES TRAINING AND UPGRADING FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500  <b>BRD OF TRUSTEES-NEW ENGLAND HLTH CARE &amp; CT NURSG HOMES TRNG &amp; UP</b>	<b>D</b> Employer Identification Number (EIN)  <b>06-1163056</b>	

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

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

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

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

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

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

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

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

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

DONNA D. FEDUS

P.O. BOX 1099  
MADISON, CT 06443

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	190943	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EMPLOYEE B

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	126634	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)

EMPLOYEE F

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	118191	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)

WACS CONSULTING LLC

1740 MCINTRYRE ST  
ANN ARBOR, MI 48105

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	106569	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)

EMPLOYEE H

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	105272	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)

EMPLOYEE A

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	99477	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)

EMPLOYEE Q

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	94212	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)

EMPLOYEE O

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	84719	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)

EMPLOYEE P

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	84103	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)

EMPLOYEE D

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	71889	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)

EMPLOYEE I

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	71390	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)

CONNECTICUT CONVENTION CENTER

100 COLUMBUS BLVD  
HARTFORD, CT 06103

(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	70224	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)

EMPLOYEE C

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	66032	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)

THREE RIVERS COMMUNITY COLLEGE

574 NEW LONDON TURNPIKE  
NORWICH, CT 06360

(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	53957	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)

RC3P TECH LLC

7 OVERLOOK TER.  
SIMSBURY, CT 06070

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	53286	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)

EMPLOYEE N

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	52774	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)

EMPLOYEE S

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	45773	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)

H-CAP EDUCATION ASSOCIATION

46-4604754

(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	38547	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)

EMPLOYEE R

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	38192	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)

TRANSFORMATIVE LDRSP STRATEGIES

PO BOX 370552  
WEST HARFORD, CT 06137

(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	32125	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)

EMPLOYEE G

06-1163056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	28293	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)

THE FOGARTY CENTER

310 MAPLE AVE SUITE 102  
BARRINGTON, RI 02806

(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	26835	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)

SWIFT RIVER CONSULTING LLC

4207 SE WOODSTOCK BLVD., STE 248  
PORTLAND, OR 97206

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	26310	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)

NOVAK FRANCELLA, LLC

61-1436956

(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	26053	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)

UNION PRINTING

45 WESTRIDGE DRIVE  
WATERBURY, CT 06708

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	23893	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)

BOSTON UNIVERSITY

04-2103547

(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	22275	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)

SALESFORCE.COM, INC.

94-3320693

(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	19501	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)

INTERPRETERS AND TRANSLATORS, INC.

06-1165742

(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	15508	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)

WETHERSFIELD HISTORICAL SOCIETY

150 MAIN ST  
WETHERSFIELD, CT 06109

(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	11200	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)

COMPLETE CARE - GLENDALE

4 HAZEL AVE  
NAUGATUCK, CT 06770

(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	10954	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)

ALZHEIMER'S ASSOCIATION

13-3039601

(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	10400	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)

PROGRESSIVE BENEFIT SOLUTIONS

14 BUSINESS PARK DR 38  
BRANFORD, CT 06405

(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	9400	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)

HARDBALL PRESS

415 ARGYLE RD, SUITE 6A  
BROOKLYN, NY 11218

(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	9169	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)

LAW OFFICE OF JOHN M CREANE

06-0941734

(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	8063	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)

INSUREON SPECIALTY PROGRAM GROUP

203 N. LASALLE, 20TH FLOOR  
CHICAGO, IL 60601

(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	6438	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)

CANON FINANCIAL SERVICES

158 GAITHER DRIVE  
MOUNT LAUREL, NJ 08054

(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	6401	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)

B&F CONSULTING

2805 TOBERMORY LANE  
RALEIGH, NC 27606

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	5000	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)

(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"/>

(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.

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

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

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>NEW ENGLAND HEALTH CARE EMPLOYEES UNION DISTRICT 1199 AND THE CT NURSING HOMES TRAINING AND UPGRADING FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BRD OF TRUSTEES-NEW ENGLAND HLTH CARE &amp; CT NURSG HOMES TRNG &amp; UP</b>	<b>D</b> Employer Identification Number (EIN) <b>06-1163056</b>

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

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	387403	197449
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	244555	218515
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	402504	338184
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	2281873	2960023
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>	67275	22600

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	45936	33499
f Total assets (add all amounts in lines 1a through 1e).....	1f	3429546	3770270
<b>Liabilities</b>			
g Benefit claims payable.....	1g	136208	169364
h Operating payables.....	1h	69794	153623
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	62592	20973
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	268594	343960
<b>Net Assets</b>			
l Net assets (subtract line 1k from line 1f).....	1l	3160952	3426310

**Part II Income and Expense Statement**

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

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	2333636	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		2333636
<b>b Earnings on investments:</b>			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	52747	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		52747
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	415000	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	415000	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	44466	
(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 .....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<b>c</b> Other income .....	<b>2c</b>		633745
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		3064594

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	485058	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>		
(3) Other .....	<b>2e(3)</b>	1801199	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		2286257
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>	267462	
(2) Contract administrator fees .....	<b>2i(2)</b>		
(3) Recordkeeping fees .....	<b>2i(3)</b>	12053	
(4) IQPA audit fees .....	<b>2i(4)</b>	14000	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>		
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>		
(7) Actuarial fees .....	<b>2i(7)</b>		
(8) Legal fees .....	<b>2i(8)</b>	8063	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	211401	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		512979
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		2799236

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		265358
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**Part III Accountant's Opinion**

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

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

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

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

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

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

(1) Name: **NOVAK FRANCELLA, LLC**

(2) EIN: **61-1436956**

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

FINANCIAL STATEMENTS

DECEMBER 31, 2024

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION**

**DECEMBER 31, 2024 AND 2023**

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the  
New England Health Care Employees Union  
and Connecticut Nursing Homes Training  
and Upgrading Fund

### Opinion

We have audited the financial statements of the New England Health Care Employees Union and Connecticut Nursing Homes Training and Upgrading Fund (the Fund), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and benefit obligations for the years then ended, and the related notes to the financial statements.

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

### Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund's ability to continue as a going concern for a reasonable period of time.

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

### **Report on Supplemental Information**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedules of Personal Care Attendants Expenses, Schedules of Administrative Expenses and Schedule of Assets Held at End of Year, together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The Schedule of Assets Held at End of Year is supplemental information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, as amended. Supplemental information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

*Novak Francella LLC*

Killingworth, Connecticut  
September 30, 2025

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**STATEMENTS OF NET ASSETS AVAILABLE  
FOR BENEFITS AND BENEFIT OBLIGATIONS**

DECEMBER 31, 2024 AND 2023

	2024	2023
<b>ASSETS</b>		
<b>INVESTMENTS</b>		
Cash equivalents	\$ 1,110,386	\$ 704,381
Certificates of deposit	1,849,637	1,577,492
Total investments	2,960,023	2,281,873
<b>RECEIVABLES</b>		
Employer contributions, net of allowance for credit losses of \$-0- for 2024 and 2023	218,515	244,555
Accrued interest	15,050	7,729
Due from State of CT-PCA	154,928	264,007
Other	110,663	95,800
Total receivables	499,156	612,091
<b>OFFICE FURNITURE AND EQUIPMENT - net</b>	33,499	45,936
<b>RIGHT OF USE ASSET</b>		
Operating lease	155,855	155,855
Accumulated amortization	(133,255)	(88,580)
Total right of use asset	22,600	67,275
<b>OTHER ASSETS</b>		
Cash	161,555	380,979
Cash - PCA	35,894	6,424
Prepaid expenses	48,143	26,297
FSA deposit	9,400	8,672
Total other assets	254,992	422,372
Total assets	3,770,270	3,429,546
<b>LIABILITIES</b>		
<b>CURRENT LIABILITIES</b>		
Accounts payable	153,601	69,795
Payroll taxes payable	22	(1)
Operating lease liability	20,973	41,619
Total current liabilities	174,596	111,413
<b>LONG-TERM LIABILITIES</b>		
Operating lease liability	-	20,973
Total liabilities	174,596	132,386

See accompanying notes to financial statements.

	<u>2024</u>	<u>2023</u>
NET ASSETS AVAILABLE FOR BENEFITS	\$ 3,595,674	\$ 3,297,160
BENEFIT OBLIGATIONS		
Tuition reimbursement benefit payable	<u>169,364</u>	<u>136,208</u>
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	<u>\$ 3,426,310</u>	<u>\$ 3,160,952</u>

See accompanying notes to financial statements.

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE  
FOR BENEFITS AND BENEFIT OBLIGATIONS**

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
<b>ADDITIONS</b>		
Investment income		
Net appreciation in fair value of investments	\$ 44,466	\$ 24,274
Interest	52,747	35,160
Total investment income	97,213	59,434
Employer contributions	2,333,636	2,284,895
Other income		
State of Connecticut-PCA agreement	599,882	635,911
HCAP	32,588	51,513
Miscellaneous	714	340
Interest on employer contributions	561	391
Total other income	633,745	688,155
Total additions	3,064,594	3,032,484
<b>DEDUCTIONS</b>		
Benefits		
Tuition	451,902	414,000
Books	19,001	17,926
Tuition vouchers	-	5,131
High school diploma program costs	63,032	91,450
Career to College	118,698	115,318
Outreach	155,940	104,656
Tutoring	75,830	73,996
Labor/Management Initiative	181,636	(1,338)
Other programs	27,411	42,419
Transition to College and Career	37,645	47,078
Marketing & Technology	95,573	88,593
Apprenticeship program	154,499	316,932
Computer lab program costs	8,212	4,313
Virtual programming	70,681	70,322
Paid voluntary trainings	18,342	-
State of CT - PCA agreement	591,550	626,857
Conferences	164,778	58,557
Rhode Island	23,314	22,322
Rhode Island PCA	(31,264)	(46,553)
Graduation	26,321	25,034
Total benefits	2,253,101	2,077,013

See accompanying notes to financial statements.

	<u>2024</u>	<u>2023</u>
DEDUCTIONS (continued)		
Administrative expenses	\$ 507,508	\$ 404,706
Credit losses	<u>5,471</u>	<u>4,993</u>
Total deductions	<u>2,766,080</u>	<u>2,486,712</u>
NET INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS	298,514	545,772
NET CHANGE IN BENEFIT OBLIGATIONS		
Increase during the year attributable to:		
Tuition reimbursement benefits	<u>(33,156)</u>	<u>(448)</u>
INCREASE IN EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	265,358	545,324
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS		
Beginning of year	<u>3,160,952</u>	<u>2,615,628</u>
End of year	<u>\$ 3,426,310</u>	<u>\$ 3,160,952</u>

See accompanying notes to financial statements.

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**NOTES TO FINANCIAL STATEMENTS**

DECEMBER 31, 2024 AND 2023

**NOTE 1. DESCRIPTION OF PLAN**

The New England Health Care Employees Union and Connecticut Nursing Homes Training and Upgrading Fund (the Fund) was established in 1985, pursuant to an agreement and declaration of trust adopted by the New England Health Care Employees Union, District 1199 (the Union), and the employers with whom District 1199 has collective bargaining agreements. The Fund is maintained pursuant to collective bargaining agreements which provide for each employer's rate of contributions, the type of work and areas of work for which contributions are payable and certain other terms governing contributions. The Fund, a welfare benefit plan, was established to provide educational training and upgrading benefits to the Fund's members who meet certain eligibility requirements of the Fund. The Fund is administered by a Board of Trustees consisting of equal representation of the contributing employers and the Union. See the Summary Plan Description (SPD) for a complete description of eligibility requirements as well as for other plan provisions.

Contributions to the Fund are made by contributing employers at the rates established by the collective bargaining agreements. Contributions and the related receivables are from nursing homes located in the State of Connecticut.

On June 24, 2022, the Board of Trustees approved to increase maximum tuition reimbursement to \$4,000 per semester/module, effective for semester/modules starting on or after August 1, 2022.

**NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Method of Accounting** - The accompanying financial statements were prepared using the accrual basis of accounting.

**Valuation of Investments** - The Trustees have appointed an investment manager and investment custodian. Subject to an investment policy adopted by the Trustees, the investment manager has discretionary authority concerning purchases and sales of investments, which consist of certificates of deposit and cash equivalents. These investments are stated at fair value, based on quoted market prices, or valued based on pricing models maximizing the use of observable inputs for similar securities, as represented by the investment custodian.

## **NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)**

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

See Note 12 for discussion of fair value measurements.

**Employer Contributions** - Employer contributions are based on a percentage of gross wages, as reported by employers, at rates contractually agreed upon. Employer contributions are accounted for as exchange transactions.

The allowance for credit losses represents the estimated losses that may be incurred in the collection of employer contributions receivable. There were \$5,471 and \$-0- of credit losses written off during the years ended December 31, 2024 and 2023, respectively.

The Fund charges interest and penalties for delinquent payment of contributions. These charges are usually not recognized as income until they are collected by the Fund.

The Fund's policy is to suspend all tuition reimbursement and computer class benefits for employees of contributing employers who are two months or more delinquent. The employer can prevent suspension of benefits by either becoming current on its contractual obligations to the Fund or by agreeing to a repayment plan.

**Use of Estimates** - The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America, requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from these estimates.

**Property and Equipment** - Property and equipment are recorded at cost and are being depreciated on a straight-line basis over the estimated useful lives of the assets, ranging from 5 to 15 years.

**Credit Risk** - The Fund maintains its cash with a financial institution deemed to be credit worthy. Cash balance is insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 in a single bank. As of December 31, 2024, cash on deposit with Bank of America did not exceed the FDIC coverage in a single bank.

## **NOTE 3. BENEFIT OBLIGATIONS**

Benefit obligations represent amounts currently payable for tuition reimbursement benefits.

**NOTE 4. PROPERTY AND EQUIPMENT**

	December 31				Depreciable Lives
	2024		2023		
Furniture and fixtures	\$ 112,595		\$ 120,746		
Accumulated depreciation	<u>80,416</u>	\$ 32,179	<u>76,794</u>	\$ 43,952	5-7 years
Carpets and construction	17,793		17,793		
Accumulated depreciation	<u>16,473</u>	1,320	<u>15,809</u>	1,984	5-10 years
Leasehold improvements	5,824		5,824		
Accumulated depreciation	<u>5,824</u>	-	<u>5,824</u>	-	15 years
		<u>\$ 33,499</u>		<u>\$ 45,936</u>	

Depreciation expense totaled \$18,712 and \$13,432 for the years ended December 31, 2024 and 2023, respectively.

**NOTE 5. FUND TERMINATION**

The Trustees expect and intend to continue the Fund indefinitely but reserve the right to amend or terminate the Fund. In the event the Fund terminates, the Trustees shall first apply the net assets to any obligations outstanding and any remaining balance in such manner as will best effectuate the purpose of the Fund.

Under no circumstances shall any portion of the Fund, directly or indirectly, revert or accrue to the benefit of any contributing employer or the Union.

**NOTE 6. TAX STATUS**

The Fund obtained its latest determination letter dated October 29, 1991, in which the Internal Revenue Service stated that the Fund, as then designed, was exempt from federal income tax under Internal Revenue Code Section 501(c)(9). The Fund has been amended since receiving this determination letter. However, the Fund's legal counsel believes that the Fund is currently designed, and the Fund's administrator believes that the Fund is currently being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, they believe that the Fund is tax-exempt under Section 501(c)(9) of the Internal Revenue Code as of the financial statement date.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Fund and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Fund is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

**NOTE 7. OBLIGATION UNDER OPERATING LEASE**

The Fund leases its facilities from the New England Health Care Employees Union, District 1199 Holding Company LLC, a related party, under an annual rental agreement through June 30, 2025. Under the lease, the monthly rent payments are \$4,136 effective July 1, 2021 and \$3,503 effective July 1, 2023. Rent expense totaled \$42,036 and \$45,834 for the years ended December 31, 2024 and 2023, respectively. The rent is based on a market analysis performed by an independent third party.

The Fund has an operating lease for their office space. The lease has a remaining lease term of one and half years. The Fund has elected to use the incremental borrowing rate as the discount rate for the leases.

The components of lease expense for the years ended December 31, 2024 and 2023 were as follows:

	<u>2024</u>	<u>2023</u>
Operating lease expense	<u>\$ 45,291</u>	<u>\$ 45,291</u>

Cash flow information related to the leases for the years ended December 31, 2024 and 2023 were as follows:

	<u>2024</u>	<u>2023</u>
Cash paid for amount included in the measurement of lease liabilities:		
Operating cash flows from operating lease	<u>\$ 42,036</u>	<u>\$ 45,834</u>
Right of use assets obtained in exchange for lease obligations:		
Operating lease	<u>\$ -</u>	<u>\$ 155,855</u>

Statements of net assets available for benefits information related to leases as of December 31 2024 and 2023 were as follows:

	<u>2024</u>	<u>2023</u>
Operating lease		
Right of use assets - gross	\$ 155,855	\$ 155,855
Right of use assets - accumulated	<u>(133,255)</u>	<u>(88,580)</u>
Right of use assets - net	<u>\$ 22,600</u>	<u>\$ 67,275</u>
Operating lease liabilities	<u>\$ 20,973</u>	<u>\$ 62,592</u>
Weighted average remaining lease term		
Operating lease	0.50 years	1.50 years
Weighted average discount rate		
Operating lease	1.04%	1.04%

**NOTE 7. OBLIGATION UNDER OPERATING LEASE (continued)**

At December 31, 2024, future minimum annual payments under this lease are as follows:

<u>Year Ending December 31,</u>	<u>Operating lease</u>
2025	\$ 21,018
Total undiscounted cash flows	21,018
Less: present value discount	(45)
Total lease liabilities	<u>\$ 20,973</u>

Subsequent to year end, the Fund renewed the lease effective July 1, 2025.

The Fund leases a copier covered by a maintenance agreement from Canon. The lease and maintenance agreement are effective through June 30, 2028 and are payable on a monthly basis. The combined monthly payments are \$622 through June 30, 2023 and \$531 effective July 1, 2023 plus maintenance and copying costs. Lease expense totaled \$6,401 and \$7,803 for the years ended December 31, 2024 and 2023, respectively.

At December 31, 2024, future minimum annual lease payments under this agreement are as follows:

<u>Year Ending December 31,</u>	<u>Amount</u>
2025	\$ 6,368
2026	6,368
2027	6,368
2028	2,123
	<u>\$ 21,227</u>

**NOTE 8. RELATED PARTY TRANSACTIONS**

The Fund paid certain expenses related to the plan operations and investment activity to various service providers. These transactions qualify as party-in-interest transactions which are exempt from the prohibited transaction rules of ERISA.

**NOTE 9. RISKS AND UNCERTAINTIES**

The Fund invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and sector risks. Due to the level of risks associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the Statements of Net Assets Available for Benefits.

**NOTE 10. PERSONAL CARE ATTENDANT (“PCA”) WORKFORCE COUNCIL**

In February 2016, an agreement was entered into between the Fund, the PCA Council (“Workforce Council”) and the PCA Training Fund Committee for the Fund to develop and administer the orientation program and provide professional development training for PCAs.

The Fund has recorded \$591,550 and \$626,857 in expenses relating to the developing and administering of the orientation program for the years ending December 31, 2024 and 2023, respectively. The Fund received \$599,882 and \$635,911 in reimbursements from the Workforce Council for the years ending December 31, 2024 and 2023, respectively. As of December 31, 2024 and 2023, respectively, the Fund held \$35,894 and \$6,424 in cash and had \$202,371 and \$15,676 in accounts payable which were included in the statement of net assets available for benefits and benefit obligations. (Reference supplemental Schedule of Personal Care Attendant Expenses.)

**NOTE 11. RECONCILIATION TO FINANCIAL STATEMENTS TO FORM 5500**

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500:

	December 31,	
	2024	2023
Net assets available for benefits per the financial statements	\$ 3,595,674	\$ 3,297,160
Less: Benefit obligations currently payable	169,364	136,208
Net assets available for benefits per the Form 5500	<u>\$ 3,426,310</u>	<u>\$ 3,160,952</u>

The following is a reconciliation of benefits paid to participants per the financial statements to the Form 5500:

	Year Ended December 31, 2024
Tuition reimbursement benefits paid to participants per the financial statements	\$ 451,902
Add: Amounts currently payable at December 31, 2024	169,364
Less: Amounts currently payable at December 31, 2023	<u>(136,208)</u>
Tuition reimbursement benefits paid to participants per the Form 5500	<u>\$ 485,058</u>

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

## NOTE 12. FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1) and the lowest priority to unobservable inputs (level 3). The three levels of the fair value hierarchy are described as follows:

### Basis of Fair Value Measurement:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Fund has the ability to access.

Level 2 - Inputs to the valuation methodology include: quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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

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

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value, as well, as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Many cash instruments have bid and ask prices that can be observed in the marketplace. Bid prices reflect the highest price that a party is willing to pay for an asset. Ask prices represent the lowest price that a party is willing to accept for an asset. For financial instruments, whose inputs are based on bid-ask prices, Morgan Stanley Smith Barney, the investment custodian, does not require that the fair value estimate always be a predetermined point in the bid-ask range. Morgan Stanley Smith Barney's policy is to allow for mid-market pricing and to adjust to the point within the bid-ask range that meets Morgan Stanley Smith Barney, the investment custodian, best estimate of fair value. For offsetting positions in the same financial instrument, the same price within the bid-ask spread is used to measure both the long and short positions.

**NOTE 12. FAIR VALUE MEASUREMENTS (continued)**

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2024 and 2023:

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
Cash equivalents	\$ 1,110,386	\$ 1,110,386	\$ -	\$ -
Certificate of deposit	1,849,637	1,849,637	-	-
Total	<u>\$ 2,960,023</u>	<u>\$ 2,960,023</u>	<u>\$ -</u>	<u>\$ -</u>

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
Cash equivalents	\$ 704,381	\$ 704,381	\$ -	\$ -
Certificate of deposit	1,577,492	1,577,492	-	-
Total	<u>\$ 2,281,873</u>	<u>\$ 2,281,873</u>	<u>\$ -</u>	<u>\$ -</u>

**NOTE 13. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN**

The Fund participates in one multiemployer defined benefit pension plan under terms of a participation agreement that covers its non-collectively bargained full time employees. The risk of participating in a multiemployer defined benefit pension plan is different from a single-employer plan in the following aspects:

- a. Assets contributed to the multiemployer defined benefit pension plan by one employer may be used to provide benefits to employees of other participating employers.
- b. If a participating employer stops contributing to the multiemployer defined benefit pension plan, the unfunded obligations of the multiemployer defined benefit pension plan may be borne by the remaining participating employers.
- c. If the Fund chooses to stop participating in any of its multiemployer defined benefit pension plans, the Fund may be required to pay those multiemployer defined benefit pension plans an amount based on the underfunded status of those multiemployer defined benefit pension plans, referred to as a withdrawal liability.

**NOTE 13. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN (continued)**

The Fund’s participation in the multiemployer defined benefit pension plan for the annual periods ended December 31, 2024 and 2023, are outlined in the table below. The zone status is based on information that the Fund received from the multiemployer defined benefit pension plan and is certified by the multiemployer defined benefit pension plan’s actuary. Among other factors, pension plans in the red zone are generally less than 65 percent funded, pension plans in the yellow zone are less than 80 percent funded, and pension plans in the green zone are at least 80 percent funded.

Legal Name of Pension Plan	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Pension Protection Act Zone Status				Expiration Date of Collective Bargaining Agreement
			Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	
New England Health Care Employees Pension Plan	22-3071963	001	Red as of 12/31/24	N/A	Red as of 12/31/23	N/A	*

\*The eligible full-time employees of the Fund participate in the New England Health Care Employees Pension Fund through a participation agreement between New England Health Care Employees Union and Connecticut Nursing Homes Training and Upgrading Fund and the Fund. The participation agreement does not have an expiration date.

Legal Name of Pension Plan	Contributions to the Pension Plan		Contributions to the Pension Plan greater than 5% of total Pension Plan Contributions (Plan year ending)		Employer Contribution Rates		Number of Employees Covered by Plan	
	12/31/2024	12/31/2023	No, Plan year ending 12/31/2024.	No, Plan year ending 12/31/2023.	12/31/2024	12/31/2023	12/31/2024	12/31/2023
New England Health Care Employees Pension Fund	\$ 88,810	\$ 77,997			9.50% through November 30, 2024 and 10.70% effective December 1, 2024 of gross payroll	9.50% of gross payroll	16	15

Legal Name of Pension Plan	Funding Improvement Plan or Rehabilitation Plan Implemented or Pending?	Surcharge paid to Pension Plan by Fund ?	Minimum contributions required in future by CBA, statutory requirements, or other contractual requirements.	
			No?	If yes, description
New England Health Care Employees Pension Fund	Yes	Yes	No	N/A

**NOTE 14. MULTIEMPLOYER PLAN PROVIDING POSTRETIREMENT BENEFITS OTHER THAN PENSIONS**

The Fund contributes to one multiemployer defined benefit health and welfare plan that provides postretirement benefits during the years ended December 31, 2024 and 2023 for its eligible non-collectively bargained employees during the years ended December 31, 2024 and 2023. The Fund remits the contributions to the multiemployer New England Health Care Employees Welfare Fund. The Fund’s contributions to the welfare plan on behalf of its eligible employees, contribution rates, and number of employees covered were as follows:

Legal Name of Plan providing postretirement benefits other than pension	Contributions to Plan		Employer contribution rates		Number of employees covered by Plan	
	12/31/2024	12/31/2023	12/31/2024	12/31/2023	12/31/2024	12/31/2023
New England Health Care Employees Welfare Fund	\$ 169,444	\$ 164,205	20% of gross payroll	20% of gross payroll	16	15

**NOTE 15. SUBSEQUENT EVENTS**

Subsequent events have been evaluated through September 30, 2025, which is the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

**SUPPLEMENTAL INFORMATION**

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**SCHEDULES OF PERSONAL CARE ATTENDANT EXPENSES**

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Staff wages	\$ 162,620	\$ 167,819
Tuition reimbursement	72,288	89,606
Orientations - wages	63,187	66,991
Virtual trainings	59,140	101,020
Staff benefits	57,914	60,372
PCA coordinator	50,629	64,053
Computer supplies and service	44,967	22,377
Payroll taxes	15,791	18,608
Temporary help	15,153	-
Orientations - other	12,131	9,026
Outside consulting	8,700	4,455
Orientations - payroll taxes	6,867	7,235
Miscellaneous	5,836	406
Office supplies and expense	5,615	4,994
Telephone	3,581	3,883
Other trainings	3,150	-
Accounting	2,600	2,600
Legal	1,050	1,538
Advertising	201	1,608
Postage and mailing	130	206
Orientations - sites	-	368
Rent	-	(308)
	\$ 591,550	\$ 626,857
Total personal care attendant expenses	\$ 591,550	\$ 626,857

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**SCHEDULES OF ADMINISTRATIVE EXPENSES**

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Salaries	\$ 204,800	\$ 158,722
Employee benefits	62,662	47,288
Computer supplies and service	41,568	22,654
Payroll taxes	29,951	22,272
Auditing and related services	26,053	20,716
Rent	25,353	21,716
Insurance	18,751	18,877
Depreciation	18,712	13,432
Office supplies and expense	16,357	18,892
Printing	15,946	12,530
Miscellaneous	15,416	7,828
Advertising	10,593	13,739
Legal	8,063	6,150
Conferences, meetings and travel	7,923	5,219
Property tax	2,685	2,244
Telephone	1,806	706
Postage and mailing	869	7,221
Website	-	4,500
	\$ 507,508	\$ 404,706
Total administrative expenses	\$ 507,508	\$ 404,706

**NEW ENGLAND HEALTH CARE EMPLOYEES UNION  
AND CONNECTICUT NURSING HOMES  
TRAINING AND UPGRADING FUND**

**SCHEDULE OF ASSETS HELD AT END OF YEAR**

DECEMBER 31, 2024

Form 5500, Schedule H, Line 4i

EIN: 06-1163056

Plan No. 501

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date Rate of Interest, Collateral, Par or Maturity Date			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
<u>Cash and cash equivalents:</u>						
* Morgan Stanley Bank		1,089,308			\$ 1,089,308	\$ 1,089,308
Cash		6,136			21,078	21,078
		Total cash and cash equivalents			<u>1,110,386</u>	<u>1,110,386</u>
<u>Certificates of deposit:</u>						
American Express Sandy UT	CD	40,000	4.400 %	10/06/25	40,000	40,083
American Express Sandy UT	CD	50,000	3.600	10/02/29	50,000	49,129
American Express Sandy UT	CD	40,000	2.250	03/30/27	40,000	38,498
Barclay's Bank CD Wilmington DE	CD	50,000	5.250	05/22/25	50,000	50,172
Bny Mellon N A CD Pittsburgh PA	CD	50,000	4.000	03/06/28	50,000	50,002
Bny Mellon N A CD Pittsburgh PA	CD	50,000	3.700	11/01/29	50,000	49,339
Capital One NA McLean VA	CD	40,000	4.450	10/05/26	40,000	40,266
Capital One BK US Glen Allen VA	CD	40,000	3.200	05/25/27	40,000	39,262
Capital One Natl Assn Mclean VA	CD	50,000	4.500	10/13/27	50,000	50,634
Capital One NA Maclean VA	CD	45,000	4.450	06/07/28	45,000	46,435
Cross Riv BK CD Teaneck NJ	CD	50,000	3.650	11/05/29	50,000	49,229
Discover BK Greenwood DE	CD	30,000	4.700	11/02/26	30,000	30,363
Discover BK Greenwood DE	CD	50,000	3.550	09/13/27	50,000	49,417
Discover BK Greenwood DE	CD	50,000	4.900	11/08/27	50,000	51,192
Discover BK Greenwood DE	CD	45,000	4.800	09/20/27	45,000	45,906
East Boston Svgs Boston, MA	CD	30,000	0.400	02/12/25	30,000	29,860
First Carolina BK Rocky MT NC	CD	50,000	0.500	12/23/25	50,000	48,263
Flagstar BK Natl Hicksville NY	CD	50,000	5.000	05/18/26	50,000	50,611
Goldman Sachs BK New York NY	CD	50,000	1.000	09/15/26	50,000	47,514
Goldmans Sachs New York	CD	50,000	3.250	10/01/29	50,000	48,380
HSBC Bank USA McLean VA	CD	30,000	1.300	05/07/25	30,000	29,692
Luna Svgs Bk IOW Lunana IA	CD	50,000	0.300	01/22/25	50,000	49,877
Luna Svgs Bk IOW Lunana IA	CD	50,000	0.450	05/18/26	50,000	47,583
Morgan Stanley Salt Lake City UT	CD	50,000	4.450	02/09/26	50,000	50,183
Morgan Stanley Salt Lake City UT	CD	50,000	4.750	04/13/28	50,000	50,089
Morgan Stanley Pri BK Natl Asn Pur NY	CD	50,000	4.650	03/08/27	50,000	50,659
Merrick Bank South Jordan UT	CD	50,000	3.800	10/31/29	50,000	49,560
Morgan Stanley Purchase NY	CD	50,000	4.550	07/17/28	50,000	50,875
MS Private Bk Purchase NY	CD	50,000	4.650	01/14/28	50,000	49,986
Nebraskaland BK North Platte NE	CD	45,000	3.750	02/24/28	45,000	44,663
Pacific Western Beverly Hills, CA	CD	25,000	0.450	09/30/25	25,000	24,329
State Bank Ind New York City NY	CD	60,000	0.900	04/14/26	60,000	57,619
Security B&T Paris TN	CD	50,000	0.450	11/30/26	50,000	46,736
Sallie Mae Ban Salt Lake City UT	CD	50,000	4.650	07/19/27	50,000	50,755
ST BK of India Chicago, IL	CD	25,000	0.950	07/10/25	25,000	24,582
Synchrony Draper UT CD	CD	45,000	4.450	08/11/28	45,000	46,232
UBS BK USA Salt Lake City UT	CD	30,000	4.700	11/03/25	30,000	30,142
UBS BK USA Salt Lake City UT	CD	45,000	4.450	05/05/28	45,000	45,628

\* A party-in-interest as defined by ERISA.

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date Rate of Interest, Collateral, Par or Maturity Date			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	<u>Certificates of deposit (continued):</u>					
UBS BK USA Salt Lake City UT	CD	45,000	4.450 %	07/07/28	\$ 45,000	\$ 45,658
Wells Fargo BK N Sioux Falls SD	CD	50,000	4.750	08/06/25	50,000	50,170
University BK Ann Arbor Mich	CD	50,000	4.050	12/16/27	50,000	50,064
	Total certificates of deposit				<u>1,860,000</u>	<u>1,849,637</u>
	Total investments				<u>\$ 2,949,308</u>	<u>\$ 2,960,023</u>

\* A party-in-interest as defined by ERISA.

**THE FINANCIAL STATEMENTS WILL BE PLACED IN THE  
ATTACHMENT FOR THE ACCOUNTANT'S OPINION**

SEE ACCOUNTANT'S OPINION FOR SCHEDULE  
OF ASSETS HELD

<b>Form 5500</b> Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b> 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). ▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB No. 1545-0047 12-19-0049 <b>2024</b> This Form is Open to Public Inspection
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**Part I Annual Report Identification Information**

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

**A** This return/report is for  a multiemployer plan  a multiple employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.)

**B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 the first return/report  the final return/report  
 an amended return/report  a short plan year return/report (less than 12 months)

**C** If the plan is a collectively-bargained plan, check here

**D** Check box if filing under:  Form 5558  automatic extension  the DFVC program  
 special extension (enter description)

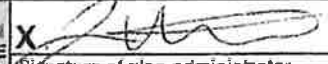

**E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here

**Part II Basic Plan Information** - enter all requested information

<b>1a</b> Name of plan NEW ENGLAND HEALTH CARE EMPLOYEES UNION DISTRICT 1199 AND THE CT NURSING HOMES TRAINING AND UPGRADING FUND	<b>1b</b> Three-digit plan number (PN) ▶ 501
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BRD OF TRUSTEES-NEW ENGLAND HLTH CARE & CT NURSG HO MES TRNG & UPGRADING FUND  77 HUYSHOPE AVENUE  HARTFORD CT 06106-7000	<b>1c</b> Effective date of plan 12/18/1985  <b>2b</b> Employer Identification Number (EIN) 06-1163056  <b>2c</b> Plan Sponsor's telephone number 860-251-6060  <b>2d</b> Business code (see instructions) 623000

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

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

<b>SIGN HERE</b> <input checked="" type="checkbox"/> 	<input checked="" type="checkbox"/> 10/13/2025	JESSE MARTIN
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b> <input checked="" type="checkbox"/> 	<input checked="" type="checkbox"/> 10/13/2025	<del>THERESA SANDERSON</del> SEAN KENNEDY
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>		
Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
--	--

<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
--	-----------------------------------

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	5,405
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	5,405
<b>a (2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	7,062
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c	<b>6d</b>	7,062
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e	<b>6f</b>	
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	41

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

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

**4J**

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

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

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