

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Department of the Treasury Internal Revenue Service

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

2024

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation

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 LOCAL 837 HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 10/01/1965
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) LOCAL 837 HEALTH AND WELFARE PLAN BOARD OF TRUSTEES
12275 TOWNSEND ROAD PHILADELPHIA, PA 19154
2b Employer Identification Number (EIN) 23-1685740
2c Plan Sponsor's telephone number 215-673-7337
2d Business code (see instructions) 493100

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

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

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

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	115
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	115
	6a(2)	55
	6b	0
	6c	0
	6d	55
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	4

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

<p>A Name of plan LOCAL 837 HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 837 HEALTH AND WELFARE PLAN BOARD OF TRUSTEES</p>	<p>D Employer Identification Number (EIN) 23-1685740</p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	418206	31	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 672	(b) Total amount of fees paid 84
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GALLAGHER BELMONT PO BOX 3009
ARLINGTON HEIGHTS, IL 60006

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
672			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GALLAGHER BENEFIT SERVICES INC 2850 W. GOLF ROAD
11TH FLOOR
ROLLING MEADOWS, IL 60008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	84	COMPENSATION	3

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	6837
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan LOCAL 837 HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 837 HEALTH AND WELFARE PLAN BOARD OF TRUSTEES		D Employer Identification Number (EIN) 23-1685740

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
GERBER LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-2611847	70939	GL-0032-VU	55	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 22715	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LABOR FIRST LLC
3000 MIDLANTIC DRIVE, SUITE 101
MOUNT LAUREL, NJ 08054

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
22715			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	189288
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

A Name of plan LOCAL 837 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 837 HEALTH AND WELFARE PLAN BOARD OF TRUSTEES	D Employer Identification Number (EIN) 23-1685740	

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

FIDELITY INVESTMENTS	PO BOX 770002 CINCINNATI, OH 45277
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

FIRST TRUST PORTFOLIOS	120 E. LIBERTY DRIVE, SUITE 400 WHEATON, IL 60187
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

GOLDMAN SACHS	PO BOX 06050 CHICAGO, IL 60606
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

INVESCO	1331 SPRING STREET NW ATLANTA, GA 30309
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

ISHARES / BLACK ROCK

400 HOWARD STREET
SAN FRANCISCO, CA 94105

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

THE VANGUARD GROUP

PO BOX 1110
VALLEY FORGE, PA 19482

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

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

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

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

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

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

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

JOHN C. DULCZAK

23-1685740

(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	211946	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)

DEBORAH PIETKOWSKI

23-1685740

(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	NONE	69179	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)

PAMELA PALMER

23-1685740

(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	64082	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)

BRIDGEWAY BENEFIT TECHNOLOGIES

3000 SOUTH LENOLA ROAD
MAPLE SHADE, NJ 08052

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	54544	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)

HORIZON HEALTHCARE SERVICES

22-0999690

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	50864	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RICHARD MCNEIL

23-1685740

(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 30 50	EMPLOYEE	44022	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)

WELLS FARGO ADVISORS

30 S 17TH STREET
PHILADELPHIA, PA 19103

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 27 49 51 72 99	NONE	33765	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FISCHER DORWART, PC

23-2247478

(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	26505	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)

BEACON ADMINISTRATORS

20000 HORIZON WAY
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?
13 11 50	NONE	25892	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)

OLD GLORY ASSET MANAGEMENT

90-0065134

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 51	NONE	12561	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)

LABOR FIRST, LLC

3000 MIDLANTIC 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?
16 12 22	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	12195	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.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
LABOR FIRST LLC	16 12	12195
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
HORIZON HEALTHCARE SERVICES, INC. 22-0999690	CONSULTING FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan LOCAL 837 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 837 HEALTH AND WELFARE PLAN BOARD OF TRUSTEES	D Employer Identification Number (EIN) 23-1685740

Part I	Asset and Liability Statement
---------------	--------------------------------------

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	225	225
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	638966	1149055
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	95235	148104
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	184833	209381
(2) U.S. Government securities	1c(2)	1126043	1047892
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	2070630	1998781
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	1048678	1080170
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	3252608	3248562
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)	235317	190014
e Buildings and other property used in plan operation.....	1e	5990	4308
f Total assets (add all amounts in lines 1a through 1e).....	1f	8658525	9076492
Liabilities			
g Benefit claims payable.....	1g	106549	171111
h Operating payables.....	1h	35136	291554
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	235317	190014
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	377002	652679
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	8281523	8423813

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	1446635	
(B) Participants.....	2a(1)(B)	39208	
(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)		1485843
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	9979	
(B) U.S. Government securities.....	2b(1)(B)	24153	
(C) Corporate debt instruments.....	2b(1)(C)	95025	
(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)		129157
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)	26839	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	84175	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		111014
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	2419715	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	2378484	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		41231
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	165479	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		177742
c Other income	2c		24303
d Total income. Add all income amounts in column (b) and enter total.....	2d		2134769

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	1089579	
(2) To insurance carriers for the provision of benefits	2e(2)	76517	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		1166096
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)	397387	
(2) Contract administrator fees	2i(2)	25892	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	16505	
(5) Investment advisory and investment management fees	2i(5)	46326	
(6) Bank or trust company trustee/custodial fees	2i(6)	6372	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	575	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)	333326	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		826383
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		1992479

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		142290
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: FISCHER DORWART, P.C.

(2) EIN: 23-2247478

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN

Financial Statements
Supplemental Schedule
And
Independent Auditor's Report
Years Ended December 31, 2024 and 2023

* * * * *

TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN

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FISCHER DORWART, P.C.

CERTIFIED PUBLIC ACCOUNTANTS
16 W. VASSAR ROAD
AUDUBON, NEW JERSEY 08106-1624

(856) 310-0990
Fax (856) 310-1769
www.fischerdorwart.com



GARY R. FISCHER, CPA
STEPHEN M. DORWART, CPA

INDEPENDENT AUDITOR'S REPORT

Pennsylvania Office
4775 Linglestown Road, Suite 100
Harrisburg, PA 17112

Board of Trustees
Teamsters Local 837 Health & Welfare Plan
Philadelphia, Pennsylvania

Opinion

We have audited the accompanying financial statements of Teamsters Local 837 Health & Welfare Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and plan benefit obligations as of December 31, 2024 and 2023, and the related statement of changes in net assets available for benefits and changes in plan benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of Teamsters Local 837 Health & Welfare Plan as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in plan benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Teamsters Local 837 Health & Welfare Plan and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

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 generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, 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 generally accepted auditing standards, we:

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


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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of administrative expenses is presented for purposes of additional analysis and is not a required part of the financial statements. The supplemental schedules of assets held at end of year and reportable transactions are presented for the purpose of additional analysis and are not a required part of the basic financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of the plan's 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 audit 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 generally accepted auditing standards.

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

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the 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.


Audubon, New Jersey
September 25, 2025

TEAMSTERS LOCAL 837 HEALTH AND WELFARE

**STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS
AS OF DECEMBER 31, 2024 AND 2023**

	2024	2023
<u>ASSETS</u>		
Cash and equivalents	\$ 125,882	\$ 56,992
Investments at fair value:		
Money market funds	83,724	128,066
Registered investment companies	3,248,562	3,252,608
Common Stock	1,080,170	1,048,678
U.S. government securities	1,047,892	1,126,043
Corporate bonds and debentures	1,998,781	2,070,630
Total investments	<u>7,459,129</u>	<u>7,626,025</u>
Receivables:		
Employer Contributions - net	1,149,055	638,966
Due from Teamsters Local 837 Pension Plan	-	16,238
Due from Teamsters Local 837 401k Plan	20,479	12,682
Accrued interest	28,818	26,897
Class action settlement receivable	22,229	-
Stop-loss and Prescripion rebates	54,527	17,392
Total receivables	<u>1,275,108</u>	<u>712,175</u>
Office improvements and equipment - net	<u>4,308</u>	<u>5,990</u>
Deposits	<u>15,016</u>	<u>15,016</u>
Prepaid expenses	<u>7,035</u>	<u>7,010</u>
Operating lease - right of use asset	<u>190,014</u>	<u>235,317</u>
TOTAL ASSETS	<u>9,076,492</u>	<u>8,658,525</u>
<u>LIABILITIES</u>		
Accounts payable for administrative expenses	31,797	35,136
Due to Teamsters Local 837 Pension Plan	259,757	-
Operating lease liability	<u>190,014</u>	<u>235,317</u>
TOTAL LIABILITIES	<u>481,568</u>	<u>270,453</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>\$ 8,594,924</u>	<u>\$ 8,388,072</u>

The Accompanying Notes are an Integral
Part of the Financial Statements

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Addition to net assets:		
Employers' contributions	\$ 940,497	\$ 848,515
Participants' contributions	39,208	41,496
Provision for uncollectible	506,138	(175,120)
Total net contributions	1,485,843	714,891
Investment income:		
Interest & dividends	240,171	212,628
Net appreciation (depreciation) in value of investments	384,452	624,893
	624,623	837,521
Less: Investment expenses	52,698	49,285
Net investment income	571,925	788,236
Total additions	2,057,768	1,503,127
Benefits paid to or for participants:		
ACA mandated fees	370	1,422
Life insurance premiums	6,837	5,784
Stop loss insurance premiums-net	69,310	143,607
Self-insured claims:		
Medical	854,996	379,214
Prescription drug claims	152,338	76,559
Dental claims	16,332	12,603
Vision care claims	1,351	1,090
	1,101,534	620,279
Less:		
COBRA contributions	2,074	-
Litigation settlement	22,229	-
Net benefit expense	1,077,231	620,279
Administrative expenses	773,685	872,966
Total benefits and expenses	1,850,916	1,493,245
Net change	206,852	9,882
Net assets available for benefits:		
Beginning of year	8,388,072	8,378,190
End of year	\$ 8,594,924	\$ 8,388,072

The Accompanying Notes are an Integral
Part of the Financial Statements

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN

STATEMENT OF PLAN'S BENEFIT OBLIGATIONS
DECEMBER 31, 2024 AND 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents:		
Health claims payable	\$ 23,111	\$ 33,549
	<u>23,111</u>	<u>33,549</u>
Other obligations for current benefit coverage, at present value of estimated amounts:		
Claims incurred but not reported	148,000	73,000
Accumulated eligibility credits	91,000	52,000
	<u>239,000</u>	<u>125,000</u>
Plan's total benefit obligation	<u>\$ 262,111</u>	<u>\$ 158,549</u>

The Accompanying Notes are an Integral
Part of the Financial Statements

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN

STATEMENT OF CHANGES IN PLAN'S BENEFIT OBLIGATIONS
DECEMBER 31, 2024 AND 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents:		
Balance at beginning of year	\$ 33,549	\$ 24,224
Claims reported and approved for payment	1,091,096	629,604
Claims paid	<u>(1,101,534)</u>	<u>(620,279)</u>
	<u>23,111</u>	<u>33,549</u>
Other obligations for current benefit coverage, at present value of estimated amounts:		
Balance at beginning of year	125,000	101,000
Net change during the year	<u>114,000</u>	<u>24,000</u>
	<u>239,000</u>	<u>125,000</u>
Plan's total benefit obligation	<u>\$ 262,111</u>	<u>\$ 158,549</u>

The Accompanying Notes are an Integral
Part of the Financial Statements

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN

NOTES TO FINANCIAL STATEMENTS

1. DESCRIPTION OF THE PLAN

The following brief description of the Teamsters Local 837 Health and Welfare Plan is provided for general information purposes only. Participants should refer to the Plan agreement for more complete information.

General

The purpose of the Plan is to provide, in accordance with the Trust, health and death benefits for all eligible employees covered by the Collective Bargaining Agreement and their families. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Benefits

The Plan provides general health, dental, disability, prescription, vision and death benefits covering full time employees and their dependents. The plan is self-insured for certain health claims, dental, prescription, vision and miscellaneous hospital charges.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying financial statements are prepared on the accrual basis of accounting and in accordance with the *Industry Audit Guide for Audits of Employee Benefit Plans* issued by the American Institute of Certified Public Accounts.

Contributions

The Plan agreement provides that the employers make monthly contributions to the Plan of a specified rate per hour or per month in accordance with various collective Bargaining Agreements.

Employers' contributions are based on remittances received during the year plus those received during the normal cut-off period. During 2021, an employer declared bankruptcy and owed the plan \$2,191,468 in delinquent contributions. The Fund collected \$1,031,505 of the delinquent contributions in July 2025. Accordingly, a provision has been made for delinquent employer contributions based on the collection.

Cash and Equivalents

Cash and equivalents represent cash on hand, operating checking accounts and cash in savings accounts.

The Health and Welfare Plan maintains cash balances in a financial institution located in the Philadelphia area. The account at this institution is insured by the Federal Deposit Insurance Corporation up to \$250,000. At certain times, the amount of deposit exceeds the insured amount. As of December 31, 2024 the balance did not exceed insured limits.

(Continued)

**TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Estimates

The process of preparing financial statements in conformity with generally accepted accounting principles requires the use of estimates and assumptions regarding certain types of assets, liabilities, revenues and expenses. Such estimates primarily relate to unsettled transactions and events as of the date of the financial statements. Accordingly, upon settlement, actual results may differ from estimated amounts.

Depreciation

Equipment and leasehold improvements are recorded at cost. Depreciation on the furniture and equipment is computed by the accelerated method. Leasehold improvements are amortized on the straight-line method.

Tax Status

The IRS has determined and informed the company by a letter that the Plan and related Trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). The Plan administrator and the Plan's tax counsel believe that the Plan is designed, and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, believe that the Plan is qualified, and the related trust is tax-exempt.

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

Subsequent Events

Management has evaluated events and transactions occurring subsequent to December 31, 2024 for items that should potentially be recognized or disclosed in these financial statements. The evaluation was conducted through the date these financial statements were available for issue.

3. INVESTMENTS

During the years ended December 31, 2024 and 2023, the Plan's investments (including investments bought, sold, and held during the year) appreciated in value by \$384,452 and \$624,893, respectively.

(Continued)

TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS

4. FAIR VALUE MEASUREMENTS

ASC 820, *Fair Value Measurements*, establishes 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 (Level 1) and the lowest priority to unobservable inputs (Level 3). The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. Level 3 inputs were used only when Level 1 or Level 2 inputs were not available. An asset's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

The three levels of the fair value hierarchy under ASC 820 are as follows:

- Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical unrestricted assets.
- Level 2: Quoted prices in markets that are not active, or inputs that are observable either directly or indirectly, for substantially the full term of the asset.
- Level 3: Prices or valuation techniques that require inputs that are both significant to the fair value measurement and unobservable (i.e. supported with little or no market activity).

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

Common stock, U.S. Treasury Notes, registered investment companies, and money market funds are valued at the closing price reported in the active market in which the individual security is traded.

Corporate bonds and debt, mortgage and asset backed securities traded in the over-the-counter market and listed securities for which no sale was reported on the last business day of the Plan year are valued based on monitoring the electronic pass-through securities TBA markets, direct input from the dealer community, interest rate movements, and other pertinent data.

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

(Continued)

**TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

4. FAIR VALUE MEASUREMENTS (Continued)

Investment securities measured at fair value on a recurring basis for which the Plan as elected the fair value option, are summarized below as of December 31, 2024 and 2023:

	Total Fair Value	Fair Value Measurements at Reporting Date Using:		
		Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<u>December 31, 2024</u>				
U.S. Government Securities	\$ 1,047,892	\$ 578,929	\$ 468,963	\$ -
Corporate bonds and debt	1,998,781	-	1,998,781	-
Registered investment companies	3,248,562	3,248,562	-	-
Common stock	1,080,170	1,080,170	-	-
Money Market Funds	83,724	83,724	-	-
Total	<u>\$ 7,459,129</u>	<u>\$ 4,991,385</u>	<u>\$ 2,467,744</u>	<u>\$ -</u>
<u>December 31, 2023</u>				
U.S. Government Securities	\$ 1,126,043	\$ 709,494	\$ 416,549	\$ -
Corporate bonds and debt	2,070,630	-	2,070,630	-
Registered investment companies	3,252,608	3,252,608	-	-
Common stock	1,048,678	1,048,678	-	-
Money Market Funds	128,066	128,066	-	-
Total	<u>\$ 7,626,025</u>	<u>\$ 5,138,846</u>	<u>\$ 2,487,179</u>	<u>\$ -</u>

Gains and losses (realized and unrealized) included in changes in net assets available for benefits for the years ended December 31, 2024 and 2023 are included in net appreciation (depreciation) in value of investments.

5. OFFICE IMPROVEMENTS AND EQUIPMENT

The following is a summary of office improvements and equipment at cost, less accumulated depreciation:

	2024	2023
Office improvements	\$ 50,259	\$ 50,259
Furniture and equipment	56,960	56,960
	107,219	107,219
Less: accumulated depreciation	102,911	101,229
	<u>\$ 4,308</u>	<u>\$ 5,990</u>

6. DEPOSITS

According to the terms of contracts with Horizon Blue Cross and Blue Shield of New Jersey, the Plan has the following deposits on account as of December 31, 2024:

Horizon Blue Cross and Blue Shield of NJ	<u>\$ 15,016</u>
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(Continued)

TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS

7. ESTIMATED BENEFIT OBLIGATIONS

The Plan's obligations for health claims incurred but not reported is an estimate of the amount due to participants (directly or indirectly) for claims incurred prior to the Plan years ended December 31, 2024 and 2023 and are estimated by the Plan's consultant in accordance with accepted actuarial principles.

For the years ended December 31, 2024 and 2023, the estimated health claims incurred but not reported are \$148,000 and \$73,000, respectively. Furthermore, estimated accumulated eligibility credits for the years ended December 31, 2024 and 2023 are \$91,000 and \$52,000, respectively.

8. RELATED PARTY TRANSACTIONS

The Health and Welfare Plan along with the Pension Plan are jointly administered. Expenses for salaries, payroll taxes, office space (See Note 9) and other expenses are paid in accordance with a formula adopted by the Trustees.

9. LEASES

The Company leases office space from an affiliated labor union. The lease is classified as an operating lease through March 2025 with automatic annual renewals if not cancelled by written notice to terminate 60 days prior. The lease calls for fixed lease payments and does not include any residual guarantees or restrictive covenants. The lease includes a year-to-year renewal option at the discretion of the Plan. The Plan expects to exercise the option and is included in the measurement of the lease asset and liability through March 2030. The Company elected not to include short-term leases (i.e. leases with initial terms of 12 months or less) on the Statement of Net Assets Available for Benefits.

The following summarizes the items on the Balance Sheet which include the amounts for operating leases as of December 31, 2024:

Operating lease right-to-use asset	<u>\$190,014</u>
Operating lease liability	<u>\$190,014</u>
Weighted average remaining lease term	5.25 years
Weighted aver discount rate	3.75%

(Continued)

**TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

9. LEASES (Continued)

The components of lease expense are as follows:

Operating lease cost \$39,550

Future minimum operating lease payments under these operating leases are:

<u>Year-end December 31</u>	
2025	39,924
2026	39,924
2027	39,924
2028	39,924
2029	39,924
2030	<u>9,981</u>
Total Future Lease Payments	\$ 209,601
Amounts Representing Interest	<u>(19,587)</u>
Present Value of Lease Liability	<u>\$ 190,014</u>

10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statement	\$ 8,594,924	\$ 8,388,072
Benefit obligations currently payable	(23,111)	(33,549)
Claims incurred but not reported	<u>(148,000)</u>	<u>(73,000)</u>
Net assets available for benefits per the Form 5500	<u>\$ 8,423,813</u>	<u>\$ 8,281,523</u>

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

	<u>2024</u>	<u>2023</u>
Benefits paid to or for participants per the financial statements	\$ 1,101,534	\$ 620,279
Current benefit obligations end of year	23,111	33,549
Current benefit obligations beginning of year	(33,549)	(24,224)
Claims incurred but not reported end of year	148,000	73,000
Claims incurred but not reported beginning of year	<u>(73,000)</u>	<u>(59,000)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 1,166,096</u>	<u>\$ 643,604</u>

(Continued)

TEAMSTERS LOCAL 837
HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS

11. PRIORITIES UPON TERMINATION

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used or diverted for purposes other than the exclusive benefit of the participants.

12. RISKS & UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such a change could materially affect the amounts reported in the statement of net assets available for benefits.

(Concluded)

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN

**ADMINISTRATIVE EXPENSES
FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023**

	2024	2023
Salaries	\$ 397,387	\$ 457,310
Payroll taxes	26,407	28,368
Employee benefits	161,271	180,379
Professional services		
Administrative & Consulting	35,892	41,215
Legal	575	5,812
Accounting	16,505	17,438
Rent	39,550	42,294
Utilities	3,378	3,694
Telephone & internet	7,479	7,986
Repairs and maintenance	851	770
Insurance	9,105	8,653
Office supplies and expense	3,417	10,069
Computer service	60,819	57,695
Postage	9,367	6,339
Conferences and meetings	-	3,189
Depreciation	1,682	1,755
	<u>1,682</u>	<u>1,755</u>
Total	<u>\$ 773,685</u>	<u>\$ 872,966</u>

The Accompanying Notes are an Integral
Part of the Financial Statements

TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN
EIN #23-1685740 THREE DIGIT PLAN #501

***SCHEDULE OF ASSETS HELD FOR
INVESTMENT PURPOSES AT END OF YEAR
December 31, 2024***

Description of Investment	Maturity Date/ No. of Shares	Interest Rate	Cost Value	Market Value
<u>U.S. Government Securities</u>				
US Treas Note	08/15/25	2.000%	150,387	152,858
U.S. Treasury Note	05/15/27	2.375%	208,574	205,932
U.S. Treasury Note	11/15/28	3.125%	219,011	220,138
FFCB	10/27/26	5.420%	152,229	151,406
FFCB	11/06/28	5.340%	195,390	195,006
FNMA	10/08/27	0.750%	118,150	122,552
<u>Corporate Bonds</u>				
American Tower Co,	02/15/26	4.400%	50,517	51,734
Ameriprise Finl	04/02/25	3.000%	51,279	48,792
Apple Inc.	05/11/27	3.200%	52,312	51,164
Arrow Electronics	01/12/28	3.875%	51,515	51,016
Assured Guaranty	09/15/28	6.125%	51,777	50,848
Athene Holding LTD	01/12/28	4.125%	49,716	50,733
Atmos Energy Corp	06/15/27	3.000%	50,802	51,994
Bank of America	10/21/27	3.248%	50,391	51,079
Brookfield Fin	01/25/28	3.900%	50,776	51,561
Cbre Services	03/01/26	4.875%	51,061	50,924
Centene	12/15/27	4.250%	52,484	52,310
Cleveland Cliffs	06/01/27	5.875%	52,229	51,705
John Deere Capital	09/15/27	4.150%	50,638	50,507
Duke Energy	09/15/25	0.900%	44,160	46,700
Encompass Health	09/15/25	5.750%	51,902	51,141
Fluor Corp	12/15/24	3.500%	50,276	49,462
Goldman Sachs Group	10/21/27	1.948%	49,410	51,234
JPM Chase	12/01/27	3.625%	52,080	51,483
Jefferies Group LLC	01/15/27	4.850%	56,663	52,091
Keysight Tech	04/06/27	4.600%	53,250	51,728
Kendryl Holdings	10/15/26	2.050%	53,184	58,001
Nasdaq Inc	06/30/26	3.850%	49,771	51,385
Ovintiv Exp Inc	01/01/26	5.375%	51,940	51,178
Pfizer Inc	09/15/28	3.600%	52,085	51,310
Polaris Inc	03/15/29	6.950%	52,063	51,576
Quanta Services	10/01/24	0.950%	51,408	50,928
Reinsurance Grp Am	09/15/26	3.950%	49,996	51,273
Seagate Hdd Cayman	06/01/27	4.875%	50,556	51,228
Silgan Holding Inc	02/01/28	4.125%	48,682	51,538
TD Bank	07/17/28	5.523%	49,919	49,800
Transdigm Inc	11/15/27	5.500%	49,722	51,097
Truist Financial	06/06/28	4.123%	52,470	52,042
United Rentals	11/15/27	3.875%	49,897	50,775
Verisign Inc	07/15/27	4.750%	51,564	51,934
Vmware Inc.	05/15/25	4.500%	52,036	51,801
Vontier Corp	04/01/26	1.800%	47,045	50,826

**TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN
EIN #23-1685740 THREE DIGIT PLAN #501**

***SCHEDULE OF ASSETS HELD FOR
INVESTMENT PURPOSES AT END OF YEAR
December 31, 2024***

Description of Investment	Maturity Date/ No. of Shares	Interest Rate	Cost Value	Market Value
Wells Fargo	02/19/25	3.000%	51,726	51,359
Westinghouse Air	09/15/28	4.700%	51,050	51,500
Westpac Banking	01/25/28	3.400%	50,248	51,024
<u>Common Stock</u>				
Abbott Laboratories	207 Shares		23,200	23,414
Accenture PLC Ireland	94 Shares		27,487	33,068
Aflac Inc	305 Shares		22,175	31,549
American Tower Corp	49 Shares		11,192	8,987
Amgen Inc	81 Shares		22,079	21,112
Analog Devices Inc	143 Shares		24,131	30,382
Apple Inc	383 Shares		54,486	95,911
Automatic Data Processing	101 Shares		24,574	29,566
Blackrock Inc	26 Shares		19,396	26,653
Broadcom Inc	186 Shares		30,264	43,122
Carlisle Companies Inc	20 Shares		9,329	7,377
Chevron Corp	150 Shares		25,604	21,726
Chubb LTD	100 Shares		22,561	27,630
Cisco Systems Inc	355 Shares		17,446	21,016
Colgate-Palmolive Co	119 Shares		9,125	10,818
Comcast Corp	386 Shares		15,056	14,487
Costco Wholesale Corp	27 Shares		12,993	24,739
Emerson Electric Co	148 Shares		14,542	18,342
Ge Aerospace	70 Shares		11,760	11,675
General Dynamics Corp	79 Shares		19,620	20,816
Grainger WW Inc	18 Shares		10,859	18,973
Illinois Tool Works Inc	96 Shares		22,291	24,342
Johnson & Johnson	141 Shares		24,450	20,391
JP Morgan Chase & Co	185 Shares		26,156	44,346
Linde PLC	67 Shares		22,222	28,051
Lowe's Companies Inc	174 Shares		36,543	42,943
L3Harris Technologies	87 Shares		17,313	18,294
McDonald's Corp	56 Shares		15,059	16,234
Microsoft Corp	225 Shares		53,958	94,838
Nextera Energy Inc	303 Shares		25,665	21,722
Nike Inc	255 Shares		28,496	19,296
PPG Industries Inc	62 Shares		8,173	7,406
Paychex Inc	170 Shares		20,270	23,837
Pepsico Inc	97 Shares		17,098	14,750
Phillips 66	198 Shares		20,865	22,558
Procter & Gamble Co	93 Shares		13,965	15,591
S&P Global Inc	42 Shares		15,758	20,917
Starbucks Corp	218 Shares		20,371	19,893
Target Corp	105 Shares		16,587	14,194
UnitedHealth Group	40 Shares		20,084	20,234
Walmart Inc	183 Shares		8,864	16,534

**TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN
EIN #23-1685740 THREE DIGIT PLAN #501**

***SCHEDULE OF ASSETS HELD FOR
INVESTMENT PURPOSES AT END OF YEAR
December 31, 2024***

Description of Investment	Maturity Date/ No. of Shares	Interest Rate	Cost Value	Market Value
WEC Energy Group Inc	163	Shares	15,808	15,329
Zoetis Inc	105	Shares	20,350	17,108
<u>Registered investment companies</u>				
Fidelity Adv Strategy Income Fund	70,824	Shares	794,219	820,851
First Trust Global Tactical Commodity Strat Fund ETF	824	Shares	18,971	19,718
Goldman Sachs Active Beta Large Cap Fund	4,144	Shares	325,992	477,414
Invesco Optimum Yld Diverdifield Commodity Strat	1,342	Shares	19,736	17,433
Invesco QQQ Trust	952	Shares	264,359	486,691
iShares Russell 2000 ETF	50	Shares	9,330	11,048
iShares Core S&P Tot ETF	951	Shares	91,991	122,318
iShares Core S&P Mid ETF	535	Shares	27,353	33,336
iShares Core S&P 500 Fed Index ETF	262	Shares	105,391	154,234
iShares Core Total ETF	2,037	Shares	93,746	92,072
iShares Core U.S. ETF	2,399	Shares	238,979	232,463
iShares JP Morgan Emerging Markets	593	Shares	52,002	52,801
iShares S&P 500 Growth	331	Shares	20,211	33,606
iShares S&P 500 Value	157	Shares	24,240	29,968
iShares Trust High Yield Corp Bond	1,605	Shares	57,472	59,048
Vanguard FTSE Developed Markets	1,767	Shares	79,014	84,498
Vanguard Intl Equity Index Emerging Markets	1,038	Shares	43,168	45,714
Vanguard Mid Cap Fund	314	Shares	67,262	82,937
Vanguard Total Stock Market Fund	5,457	Shares	402,424	392,413
<u>Money Market Funds</u>				
GS FS Government Fund Institutional				27,456
Wells Fargo Temporary Cash Fund				56,268
Total Assets Held For Investment Purposes				<u>\$ 7,459,129</u>

**TEAMSTERS LOCAL 837 HEALTH AND WELFARE PLAN
EIN #23-1685740 THREE DIGIT PLAN #501**

**SCHEDULE OF REPORTABLE TRANSACTIONS
FORM 5500, SCHEDULE H, PART IV, ITEM 4(j)
DECEMBER 31, 2024**

(a) Party Involved	(b) Description of asset	(c) Purchase Price	(d) Selling Price	(e) Lease rental	(f) Expense incurred	(g) Cost of Asset	(h) Current Value	(i) Net Gain
	Wells Fargo National Bank West	\$ 840,613	-	-	-	-	\$ 840,613	
	Wells Fargo National Bank West		\$ 869,743			869,743	869,743	-
	GS FS Government Fund Institutional	1,402,115					1,402,115	
	GS FS Government Fund Institutional		1,417,326			1,417,326	1,417,326	-

**SEE ACCOUNTANT'S OPINION FOR SCHEDULE OF
REPORTABLE TRANSACTIONS**

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

**SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD**