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
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/1992

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)
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES
PHILADELPHIA AND VICINITY

1319 LOCUST STREET
PHILADELPHIA, PA 19107

2b Employer Identification Number (EIN) 23-2627429

2c Plan Sponsor's telephone number 215-735-5720

2d Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	DIONNE GARY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] 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**	2796
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	**6a(1)**	1424
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	1287
b	Retired or separated participants receiving benefits	**6b**	1325
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2612
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	15

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 4D 4E 4F 4K 4L 4Q 4U

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES

D Employer Identification Number (EIN)
23-2627429

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
DELTA DENTAL OF PENNSYLVANIA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1667011	54798	79199/20380	2244	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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

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

Part II Investment and Annuity Contract Information

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

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)	0
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)	0
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** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	233233
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 [X] 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
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES

D Employer Identification Number (EIN)
23-2627429

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
HUMANA 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
39-1263473	73288	329896	432	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
20333	0

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
1000 MIDLANTIC DRIVE - SUITE 100
MOUNT LAUREL, NJ 08054-1511

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
20333			

(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)	0
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)	0
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** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ MEDICARE GROUP PLAN D PRESCRIPTION

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	1090556
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 [X] 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.**

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OMB No. 1210-0110

2024

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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
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES

D Employer Identification Number (EIN)
23-2627429

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
HUMANA INSURANCE COMPANY OF NEW YORK

(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
20-2888723	12634	329900	3	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
138	0

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
1000 MIDLANTIC DRIVE - SUITE 100
MOUNT LAUREL, NJ 08054-1511

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
138			

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

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

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

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

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(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)	0
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)	0
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** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	7437
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 [X] 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
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES

D Employer Identification Number (EIN)
23-2627429

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
HCC LIFE INSURANCE CO. (TOKIO MARINE)

(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
35-1817054	92711	HCL41128	1315	12/01/2023	11/30/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	33393

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 BENEFIT SERVICES, INC.
PO BOX 95287
CHICAGO, IL 60694-5287

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	33393	OTHER OVERIDE PAYMENTS	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)	0
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)	0
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** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	834829
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 [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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	**B** Three-digit plan number (PN) ▶
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES	23-2627429

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).. . . . . [X] 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

CARILLON TOWER ADVISERS INC

47-2484963

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

ROBERT W BAIRD & CO INC

39-6037917

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

FIDELITY MANAGEMENT & RESEARCH CO

04-2033129

(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)

INDEPENDENCE BLUE CROSS

23-2184623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	885118	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PENSION FUND FOR HHCE PHILADELPHIA

23-2627428

(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	RELATED ORG.	363838	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PAYER MATRIX, LLC

81-3946362

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	218141	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

GALLAGHER (ARTHUR J. GALLAGHER)

36-2481781

(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	150000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TINA GLENN

23-2627429

(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	106972	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LABOR FIRST

06-1750191

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	84783	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

NATESHE WILLIAMS

23-2627429

(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	83015	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ERIC BROOKS

23-2627429

(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	81964	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	68842	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PAMELA A SMITH-STRITE

23-2627429

(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	63010	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(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	61100	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPIRX HEALTH

47-1226691

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	60161	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

MORGAN, LEWIS & BOCKIUS LLP

23-0891050

(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	56659	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SHELDON WILLIAMS

23-2627429

(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	53900	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EVAN SMITH

23-2627429

(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	50437	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

BENEFIT3 INC

301 OXFORD AVLLEY RD, STE 202B
YARDLEY, PA 19067

(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	47516	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

GLENDELLE CAMERON-DIXON

12 CARDENTI CT
NEWARK, DE 19702

(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	45389	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ADRIAN HURST

23-2627429

(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	42329	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

EVELYN ALAMEDA

23-2627429

(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	37243	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BERTA SHKODRA

23-2627429

(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	35168	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PRINCIPAL CUSTODY SOLUTIONS

42-0127290

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 65	NONE	32684	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

BLAIR DEVALIA

23-2627429

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	30904	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INVESTMENT PERFORMANCE SERVICES LLC

58-2432390

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	28792	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

O'DONOGHUE & O'DONOGHUE LLP

53-0120528

(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	27146	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

SEGALL BRYANT & HAMILL LLC

46-6418945

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	19499	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CYNTHIA JONES-BROOKS

5433 N LAWRENCE ST, 1ST FL
PHILADELPHIA, PA 19120

(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	18072	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WORK & WELL INC

22-3116423

(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	9120	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

(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)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES

D Employer Identification Number (EIN)
23-2627429

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	294038	305034
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3455511	2147353
(2) Participant contributions	1b(2)	64120	29127
(3) Other	1b(3)	1376030	1442065
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	16649892	8460657
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	3899372	6071955
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	2006802	1881531
(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)	31240091	48476310
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	14590	12621
f Total assets (add all amounts in lines 1a through 1e)	1f	59000446	68826653
Liabilities			
g Benefit claims payable	1g	1266846	1448076
h Operating payables	1h	154305	165732
i Acquisition indebtedness	1i		
j Other liabilities	1j	153309	9482
k Total liabilities (add all amounts in lines 1g through1j)	1k	1574460	1623290
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	57425986	67203363

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)	26886901	
(B) Participants	2a(1)(B)	465550	
(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)		27352451
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	719590	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)	245606	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	100185	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		1065381
(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)	1571336	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		1571336
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	46342244	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	46362780	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		-20536
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	-173056	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		-173056

		(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)		764882
c Other income	2c		124095
d Total income. Add all **income** amounts in column (b) and enter total	2d		30684553
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	16253345	
(2) To insurance carriers for the provision of benefits	2e(2)	2296011	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		18549356
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)	698643	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	61100	
(5) Investment advisory and investment management fees	2i(5)	48291	
(6) Bank or trust company trustee/custodial fees	2i(6)	32684	
(7) Actuarial fees	2i(7)	159120	
(8) Legal fees	2i(8)	83805	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	1274177	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		2357820
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		20907176
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		9777377
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) [X] 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)** [X] 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
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.)	4a		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.)	4b		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.)	4c		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.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	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?	4f		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?	4g	X		1881531
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?	4h		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.)	4i	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.)	4j	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?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
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.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] 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 _____.

BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES - PHILADELPHIA AND VICINITY

FINANCIAL STATEMENTS

DECEMBER 31, 2024

BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES - PHILADELPHIA AND VICINITY

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

CONTENTS

Novak | Francella
LLC | CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Benefit Fund for Hospital and Health Care Employees
Philadelphia and Vicinity

Opinion

We have audited the financial statements of the Benefit Fund for Hospital and Health Care Employees Philadelphia and Vicinity (the 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 of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in 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 Plan 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 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 the 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 Plan'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 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 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 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 Assets Held at End of Year, Schedule of Reportable Transactions, and Schedules of Administrative Expenses, 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 supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represent supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. The supplemental 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 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

Bala Cynwyd, Pennsylvania
October 6, 2025

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
Assets		
Investments - at fair value		
Corporate obligations	$ 6,071,955	$ 3,899,372
Limited partnership - real estate	1,881,531	2,006,802
Fixed income mutual funds	43,196,116	27,888,345
Equity mutual fund	5,280,194	3,351,746
Money market mutual fund	8,460,657	16,649,892
Total investments	64,890,453	53,796,157
Receivables		
Employer contributions	2,147,353	3,455,511
Stop loss reimbursements	159,088	88,044
Participant co-pay	29,127	64,120
Interest	111,504	127,758
Total receivables	2,447,072	3,735,433
Cash	305,034	294,038
Property and equipment - at cost		
Office furniture and fixtures	65,452	65,452
Computers and equipment	57,926	56,945
Leasehold improvements	70,279	70,279
	193,657	192,676
Less accumulated depreciation and amortization	(181,036)	(178,086)
Net property and equipment	12,621	14,590
Prepaid expense	62,297	56,285
Deposits	1,109,176	1,103,943
Total assets	68,826,653	59,000,446

See accompanying notes to financial statements.

Liabilities and Net Assets	2024	2023
Liabilities		
Accrued administrative expenses	$ 165,732	$ 154,305
Due to related funds	9,482	153,309
Total liabilities	175,214	307,614
Net assets available for benefits	$ 68,651,439	$ 58,692,832

See accompanying notes to financial statements.

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
Additions		
Investment income		
Net appreciation in fair value of investments	$ 571,290	$ 1,440,985
Interest	2,636,717	2,104,011
	3,208,007	3,544,996
Less investment expenses	(48,291)	(42,650)
Investment income - net	3,159,716	3,502,346
Contributions		
Employer contributions	26,886,901	28,879,161
Participants co-pay	449,183	640,169
COBRA and self-pay	16,367	7,628
Total contributions	27,352,451	29,526,958
Other income	124,095	238,599
Total additions	30,636,262	33,267,903
Deductions		
Cost of benefits		
Self-insured benefits:		
Medical	11,402,128	12,109,796
Prescription	3,344,498	3,197,385
Disability	774,756	838,561
Other	550,733	602,176
	16,072,115	16,747,918
Insured benefits:		
Prescription	1,539,747	1,856,059
Dental	213,260	245,101
Stop loss insurance	543,004	819,550
Total cost of benefits	18,368,126	19,668,628

See accompanying notes to financial statements.

	2024	2023
DEDUCTIONS (continued)		
Fees mandated by ACA	$ 7,512	$ 7,753
Medical and prescription administrative fees	945,279	985,028
Administrative expenses	1,356,738	1,431,502
Total deductions	20,677,655	22,092,911
NET INCREASE	9,958,607	11,174,992
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	58,692,832	47,517,840
End of year	$ 68,651,439	$ 58,692,832

See accompanying notes to financial statements.

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents		
Claims payable and incurred but not reported	$ 1,448,076	$ 1,266,846
Postemployment benefit obligations - net of amounts currently payable		
Accumulated eligibility	47,932	50,611
Total benefit obligations other than postretirement benefit obligations	1,496,008	1,317,457
Postretirement benefit obligations - net of amounts currently payable		
Current retirees, beneficiaries and dependents	109,156,174	113,418,330
Other participants fully eligible for benefits	55,110,643	63,211,970
Other participants not fully eligible for benefits	39,264,846	46,597,594
Total postretirement benefit obligations	203,531,663	223,227,894
Total benefit obligations	$ 205,027,671	$ 224,545,351

See accompanying notes to financial statements.

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents		
Balance at beginning of year	$ 1,266,846	$ 1,453,654
Increase (decrease) during the year attributable to changes in claims payable and incurred but not reported	181,230	(186,808)
Balance at end of year	1,448,076	1,266,846
Postemployment benefit obligations - net of amounts currently payable		
Balance at beginning of year	50,611	64,509
Decrease during the year attributable to changes in accumulated eligibility	(5,463)	(17,143)
Increase during the year attributable to interest	2,784	3,245
Balance at end of year	47,932	50,611
Total benefit obligations other than post-retirement benefit obligations	1,496,008	1,317,457
Postretirement benefit obligations - net of amounts currently payable		
Balance at beginning of year	223,227,894	193,803,611
Increase (decrease) during the year attributable to		
Interest	11,020,950	5,484,864
Actuarial loss/(gain) and changes in assumptions	(27,116,369)	27,909,447
Benefits paid	(8,247,045)	(8,031,835)
Benefits earned	4,646,233	4,061,807
Balance at end of year	203,531,663	223,227,894
Total benefit obligations	$ 205,027,671	$ 224,545,351

See accompanying notes to financial statements.

BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES - PHILADELPHIA AND VICINITY

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE HEALTH & WELFARE PLAN

The following description of the Benefit Fund for Hospital and Healthcare Employees - Philadelphia and Vicinity (the Plan) provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions.

The Plan is a multiemployer welfare plan and has been designed to help participants meet the cost of medical, hospitalization, disability, and death, to the extent that it is not available from other sources. The Plan and related trust were established on January 1, 1991. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan is self-administered and, except for dental and prescription claims for Medicare-eligible retirees, is self-insured. The Plan provides health benefits (medical, hospital, surgical, major medical, and dental), prescription drug, death and accidental death and dismemberment and disability benefits.

Participants and their covered dependents are eligible under the Plan on the day following the day that the employer has made 30 consecutive days of contributions to the Plan on their behalf. As a new employee, the employer is required to make contributions to the Plan the day after the end of the probationary period or other period as specified in the collective bargaining agreement between the Union and the employer (provided they are actively at work).

The Plan receives contributions pursuant to a number of collective bargaining agreements entered into between District 1199C and the contributing employers based on an agreed upon rate multiplied by the gross wages paid. As the Plan is a multiemployer fund, costs are calculated on a pooled basis.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Investments and Income Recognition - Investments in mutual funds and corporate obligations are carried at fair value as provided by the investment custodian, which generally represents quoted market price or net asset value of the mutual funds as of the last business day of the year. The investment in the limited partnership is carried at estimated fair value provided by management of the limited partnership. Purchases and sales are recorded on a trade-date basis. Interest and dividends are recorded on the accrual basis. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Contributions Receivable - Employer contributions due but not paid prior to year end are recorded as contributions receivable. The Plan believes that the receivables are fully collectible; therefore, no allowance for credit losses is recorded.

As of December 31, 2024, the Plan recorded $2,147,353 of contributions related to 2024 there were not received until 2025.

Payment of Benefits - Benefits are recorded when paid.

Benefit Obligations - Claims incurred but not reported, accumulated eligibility liability and postretirement benefit obligations are determined by the Plan's consultant based on the latest data and past experience of the Plan.

Property and Equipment - Office furniture and equipment and leasehold improvements are carried at cost. Major additions are capitalized, while replacements, maintenance, and repairs which do not improve or extend the useful lives of the respective assets are expensed currently. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the related assets. The useful lives for major classes of assets are 10 years for furniture and fixtures, 5 years for equipment and 31.5 years for leasehold improvements. Depreciation expense totaled $2,951 and $3,316 for the years ended December 31, 2024 and 2023, respectively.

Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

Stop Loss Coverage - The Plan has entered into a stop loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount). Refunds are netted with stop loss premiums in the statements of changes in net assets available for benefits.

NOTE 3. 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 for or diverted to purposes other than the exclusive benefit of the participants.

NOTE 4. TAX STATUS

The Plan obtained its latest determination letter, dated March 10, 1994, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements under Section 501(c)(9) of the Internal Revenue Code and was, therefore, not subject to tax under present Federal income tax laws. The Plan has been amended since receiving the determination letter. The Plan's Trustees and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

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 U. S. Federal, state, or local taxing authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Typically, Plan years will remain open for three years; however, this may differ depending upon the circumstances of the Plan.

NOTE 5. FUNDING POLICY

The Plan is funded by contributions from participating employers under the terms of collective bargaining agreements (CBA). The contributions are due on a monthly basis. It is the policy of the Trustees to pursue monies due. The contribution rate is 35.1% of gross payroll of covered participants.

NOTE 6. 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 Plan) 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.

NOTE 6. FAIR VALUE MEASUREMENTS (continued)

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.

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
Fixed income mutual funds	$ 43,196,116	$ 43,196,116	$ -	$ -
Equity mutual fund	5,280,194	5,280,194	-	-
Money market mutual fund	8,460,657	8,460,657	-	-
Corporate obligations	6,071,955	6,071,955	-	
Total assets in the fair value hierarchy	63,008,922	$ 63,008,922	$ -	$ -
Investments measured at NAV	1,881,531			
Total investments	$ 64,890,453			

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
Fixed income mutual funds	$ 27,888,345	$ 27,888,345	$ -	$ -
Equity mutual fund	3,351,746	3,351,746	-	-
Money market mutual fund	16,649,892	16,649,892	-	-
Corporate obligations	3,899,372	3,899,372	-	
Total assets in the fair value hierarchy	51,789,355	$ 51,789,355	$ -	$ -
Investments measured at NAV	2,006,802			
Total investments	$ 53,796,157			

In accordance with Subtopic 820-10, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statement of net assets available for benefits.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the period.

For the years ended December 31, 2024 and 2023, there were no transfers in or out of Levels 1, 2, or 3.

NOTE 6. FAIR VALUE MEASUREMENTS (continued)

The unfunded commitments and redemption information are as follows at December 31, 2024 and 2023:

	2024 Fair Value	2023 Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Limited partnership - real estate:					
Boyd Watterson State Government Fund LP	$ 1,881,531	$ 2,006,802	$ -	Quarterly	60 days
	$ 1,881,531	$ 2,006,802	$ -		

The Boyd Watterson State Government Fund LP's objective is to provide income stability and capital preservation while seeking to deliver excess returns with moderate risk over market cycles by investing predominantly in commercial real estate properties leased to State Governments Tenants. This will include single-tenant, multi-tenant, recently or to-be-constructed build-to-suit properties with the development risk borne by the developers/sellers. Investments undertaken by the Fund may take the form of (i) individual real estate or real estate-related assets or (ii) equity or other interests in entities that own or control such real estate or real estate-related assets.

NOTE 7. RELATED PARTY TRANSACTIONS

The Plan has common Trustees and a shared administrative office with the Pension Fund for Hospital and Health Care Workers - Philadelphia and Vicinity (the Pension Fund). The Plan makes contributions to the Pension Fund to provide pension benefits for employees of the Plan. In addition, shared operating expenses are paid by the Pension Fund initially and then reimbursed by the Plan. Shared expenses are allocated based on the assigned responsibilities of the applicable shared employees. The recorded activity for shared expenses with the Pension Fund is as follows:

	2024	2023
Beginning of year due from (to) related parties and affiliates for shared administrative services	$ (153,309)	$ (347,442)
Expenses paid by the Pension Fund on behalf of the Fund	(886,842)	(926,155)
Repayments to related parties	1,030,669	1,120,288
End of year due from (to) related parties and affiliates for shared administrative services	$ (9,482)	$ (153,309)

The Plan has common Trustees with the District 1199C Legal Fund (the Legal Fund). The Plan makes contributions to the Legal Fund to provide legal benefits for employees of the Plan. During the years ended December 31, 2024 and 2023, the Plan made contributions to the Legal Fund of $1,135 and $1,200, respectively.

NOTE 7. RELATED PARTY TRANSACTIONS (continued)

The Plan has common Trustees with the Training and Upgrading Fund for Hospital and Health Care Workers - Philadelphia and Vicinity (the Training Fund). The Plan makes contributions to the Training Fund on behalf of its employees. During the years ended December 31, 2024 and 2023, the Plan made contributions to the Training Fund of $5,705 and $6,240, respectively.

Principal-Custody Solutions is the Plan's investment custodian. As noted on the Schedule of Assets Held at End of Year and the Schedule of Reportable Transactions, the Plan's investment in the Allspring Government Money Market Fund is a party-in-interest transaction as defined by ERISA.

The transactions identified above qualify as transactions which are exempt from the prohibited transaction rules of ERISA.

NOTE 8. POSTRETIREMENT BENEFIT OBLIGATIONS

The Plan provides certain retired participants with medical, hospital, dental, prescription, vision, and death benefits. Those retirees eligible for benefits must meet defined requirements such as being eligible for benefits immediately prior to their retirement and having a minimum number of pension credits. At the date of a participant's retirement, if the participant has earned these benefits, he or she is eligible for life.

The postretirement benefit obligations represent the actuarial present value of those estimated future benefits that are attributed to participants' service rendered to December 31, 2024 and 2023. Postretirement benefits include future benefits expected to be paid to or for currently retired participants and their beneficiaries and dependents, active participants, and their beneficiaries and dependents after retirement from service and COBRA benefits. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by the Plan's actuary and is the amount that results from applying actuarial assumptions to historical claims cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

The 2024 obligation decreased since the prior valuation primarily due to a large reduction in the number of plan participants and lower than anticipated claims experience and by the effect of the discount rate increase.

NOTE 8. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

The health care cost trend assumptions are used to project the cost of health care in future years. The following annual trends are based on the current HCA Consulting trend study and are applied on a select and ultimate basis. Select trends are reduced 0.25% each year until reaching the ultimate trend rate.

Expense Type	Select	Ultimate
Pre-Medicare	7.45%	4.00%
Post-Medicare	6.45%	4.00%
Administrative fees	7.45%	4.00%
Stop Loss fees	4.00%	4.00%
Medicare Part B Premium (2024)	3.50%	3.50%
Medicare Part B Premium (2023)	3.50%	3.50%

The following were other significant assumptions used in the valuations as of December 31, 2024 and 2023:

Discount rate: 5.50% at December 31, 2024
5.03% at December 31, 2023

Mortality:
Healthy and Disabled: PRI-2012 mortality table projected generationally using MP-2021, applied on a gender-specific basis for 2024.
RP-2014 mortality table projected generationally using MP-2021, applied on a gender-specific basis for 2023.

Turnover: Illustrative rates are shown below:

Years of Service	Rate of Termination for All Causes Other than Death or Disability During the First Five Years of Employment	
	Males	Females
0	31%	44%
1	25%	38%
2	19%	33%
3	14%	29%
4	10%	28%

NOTE 8. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

Rate of Termination for All Causes Other than Death, Disability, or Retirement After the First Five Years of Employment

Attained Age	Males	Females
25	9%	25%
30	6%	15%
35	4%	8%
40	2%	4%
45	2%	3%
50	1%	2%
55	1%	1%
60	0%	0%

Participants who meet the eligibility requirements are assumed to begin receiving benefits upon termination.

Retirement Ages — In addition to eligible participants terminating employment under the turnover tables above. Retirement eligibility assumed to be age and service at which participants are first eligible to receive retirement benefits.

For eligible employees, the assumed probability of retiring is as follows:

Age	Probability of Retiring	Age	Probability of Retiring
55	0.030	63	0.100
56	0.030	64	0.100
57	0.030	65	0.750
58	0.030	66	0.333
59	0.030	67	0.333
60	0.030	68	0.333
61	0.030	69	0.333
62	0.350	70	1.000

Sensitivity: A one percentage point increase in the Assumed Health Care Cost Trend Rate would result in an increase in the total benefit obligations by $31,597,878 in 2024 and $36,037,501 in 2023.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) became effective January 1, 2006. The Act introduces a prescription drug benefit under Medicare (Medicare Part D) as well as Federal subsidy to sponsors of retiree health care benefit plans that provide a benefit that is at least actuarially equivalent to Medicare Part D. The Plan has determined that benefits provided by the Plan are at least actuarially equivalent to Medicare Part D.

NOTE 8. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

The Plan was entitled to Medicare Part D subsidies totaling $0 for the years ended December 31, 2024 and 2023. Following is additional detail on the future payout projections as of December 31, 2024:

Year Ending	Payout Excluding Impact of Drug Subsidy
2025	$ 9,084,326
2026	9,840,130
2027	10,451,476
2028	10,884,108
2029	11,416,596
2030-2034	63,482,430

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

NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	2024	2023
Net assets available for benefits as reported on the financial statements	$ 68,651,439	$ 58,692,832
Benefit obligations currently payable and incurred but not reported	(1,448,076)	(1,266,846)
Net assets available for benefits as reported on Form 5500	$ 67,203,363	$ 57,425,986

The following is a reconciliation of total benefits as reported on the financial statements for the year ended December 31, 2024, to the balances as reported on Form 5500:

Benefits paid to or for participants per the financial statements	$ 18,368,126
Add: Claims payable and incurred but not reported at end of year	1,448,076
Less: Claims payable and incurred but not reported at beginning of year	(1,266,846)
Total benefits as reported on Form 5500	$ 18,549,356

NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (continued)

Claims payable and incurred but not reported are included in the Statements of Benefit Obligations in the financial statements but are included as liabilities on Form 5500.

NOTE 10. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and sector risks. Due to the level of risk 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.

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

NOTE 11. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN

Employees of the Benefit Fund and Pension Plan participate in the multiemployer defined benefit pension plan under the terms of participation agreements that cover their union-represented and non-collectively bargained employees. For shared employees, the Pension Plan remits the contributions to the multiemployer defined benefit pension plan for the shared employees on behalf of the Benefit Fund as well as the Pension Plan. The Benefit Fund reimburses the Pension Plan for its share of the contributions based on a cost allocation. The risks of participating in the multiemployer defined benefit pension plan are 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 Benefit Fund and Pension Plan choose to stop participating in the multiemployer defined benefit pension plan, the Benefit Fund and Pension Plan may be required to pay the multiemployer defined benefit pension plan an allocated amount based on the underfunded status of the multiemployer defined benefit pension plan, referred to as a withdrawal liability.

NOTE 11. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN (continued)

The Benefit Fund's and Pension Plan's participation in this multiemployer defined benefit pension plan for the annual periods ended December 31, 2024 and 2023, is outlined in the table below. The zone status is based on information that the Benefit 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.

			Pension Protection Act Zone Status				
Legal Name of Pension Plan	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	Expiration Date of Collective Bargaining Agreement
Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity	23-2627428	001	Red as of 01/01/2024	Yes	Red as of 01/01/2023	Yes	*

* The employees of the Benefit Fund and Pension Plan participate in the Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity through a participation agreement between the Plan and Pension Plan and the Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity. The participation agreement does not have an expiration date.

	Contribution paid by the Benefit Fund directly to the Pension Plan		Contributions to the Pension Plan greater than 5% of total Pension Plan contributions (Plan year ending)		Employer Contribution Rates of the Pension Plan		Number of Employees Covered by Pension Plan for which the Benefit Fund contributes directly to the Pension Plan	
Legal Name of Pension Plan	12/31/2024	12/31/2023			12/31/2024	12/31/2023	12/31/2024	12/31/2023
Pension Fund for Hospital and Health Care Employees – Philadelphia and Vicinity	$0	$0	No, Plan year ending 12/31/2024.	No, Plan year ending 12/31/2023.	21.55% of eligible compensation	21.55% of eligible compensation	4	4

The Benefit Fund reimbursed the Pension Plan $44,924 and $44,136 during the years ended December 31, 2024 and 2023, respectively, for the Plan's allocated share of the pension contributions for shared employees participating in the Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity.

	Funding Improvement Plan or Rehabilitation Plan Implemented or	Surcharge paid to Pension Plan by the	Minimum contributions required in future by CBA, statutory requirements, or other contractual requirements.	
Legal Name of Pension Plan	Pending?	Plan?	No?	If yes, description
Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity	Rehabilitation Plan Implemented	No	No	N/A

NOTE 12. MULTIEMPLOYER PLAN THAT PROVIDES POSTRETIREMENT BENEFITS OTHER THAN PENSION

The Benefit Fund and Pension Plan contribute to a multiemployer defined benefit health and welfare plan that provides post-retirement benefits for their non-collectively bargained employees during the years ended December 31, 2024 and 2023. For shared employees, the Pension Plan remits the contributions to the multiemployer health and welfare plan that provides post-retirement benefits for the shared employees on behalf of the Benefit Fund. The Benefit Fund reimburses the Pension Plan for its share of the contributions based on an even split of the shared employees. Information about these health and welfare plans is below:

Legal Name of Plan providing postretirement benefits other than pension	Contribution paid by the Benefit Fund directly to the Fund		Employer contribution rates of the Fund		Number of employees covered by the Benefit Fund for which the Plan contributes directly to the Fund	
	12/30/2024	12/30/2023	12/30/2024	12/30/2023	12/30/2024	12/30/2023
Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity	$0	$0	35.1% of eligible compensation	35.1% of eligible compensation	4	4

The Benefit Fund reimbursed the Pension Plan $66,285 and $64,355 during the years ended December 31, 2024 and 2023, respectively, for the Plan's allocated share of the welfare contributions for shared employees participating in the Plan for Hospital and Health Care Employees - Philadelphia and Vicinity.

The Benefit Fund is self-administered and, except for certain hospitalization, medical and dental claims, is self-insured. The Plan provides post-retirement health benefits (medical, hospital, surgical, major medical, and dental), prescription drug, death and accidental death and dismemberment, disability, hearing aid and vision benefits.

NOTE 13. CASH CONCENTRATION

The Plan maintains its cash with one financial institution deemed to be credit worthy. The balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000. As of December 31, 2024, cash on deposit exceeded the FDIC insured limit of $250,000 in a single bank by $55,034.

NOTE 14. DEPOSITS

The New Jersey Department of Labor held a deposit for the Plan totaling $189,168 and $183,935 at December 31, 2024 and 2023, respectively. The deposit is used to fund disability claims that have not yet been invoiced.

Independence Blue Cross held a deposit for the Plan totaling $920,008 at December 31, 2024 and 2023. The deposit is used to fund medical claims that have not yet been invoiced.

NOTE 15. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Plan is subject to certain fees mandated by the Patient Protection and Affordable Care Act. Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are effective for seven years, through 2018. For the years ended December 31, 2024 and 2023, the Plan paid $7,591 and $7,753 in PCORI fees, respectively. The Further Consolidated Appropriations Act of 2020 extended the PCORI fee obligation through plan years ending October 1, 2029. The fee is equal to $3.00 per covered life for each of the 2024 and 2023 calendar years.

NOTE 16. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through October 6, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Schedules of Administrative Expenses

Years Ended December 31, 2024 and 2023

	2024	2023
Personnel costs		
Salaries	$ 476,953	$ 493,063
Employee benefits	221,690	247,508
Payroll taxes	34,900	39,455
Professional fees		
Legal	83,805	122,515
Consulting	159,120	160,080
Accounting, audit, payroll compliance reviews and government filings	61,100	53,500
Office and data processing		
Biometric screening expense	557	709
Data processing	68,842	61,925
Insurance	50,404	51,872
Printing	884	12,155
Office expense	14,760	16,989
Computer expense	48,481	49,125
Equipment rental and maintenance	20,206	25,581
Telephone	6,902	6,666
Seminars	15,025	19,670
Bank charges	32,684	19,616
Depreciation and amortization	2,951	3,316
Postage and delivery	6,167	6,310
Storage	13,695	10,265
Membership fees	508	1,515
Rent	29,938	27,443
Meetings	7,166	2,224
Total administrative expenses	$ 1,356,738	$ 1,431,502

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Schedule of Assets Held at End of Year

December 31, 2024

Schedule H, Line 4i

EIN: 23-2627429
Plan No.: 501

(a)	(b)	(c) Description of Investment Including Maturity Date, Rate of interest, Collateral, Par or Maturity Value			(d)	(e)
	Issuer, Borrower	Type	Shares/ Principal	Interest Rate	Maturity Date	Cost	Current Value
	Corporate obligations:						
	Aecom	Bond	131,000	5.125 %	03/15/27	$ 128,698	$ 129,742
	Aircastle LTD	Bond	128,000	4.250	06/15/26	123,858	126,637
	Asbury Automotive Group	Bond	133,000	4.500	03/01/28	124,614	127,481
	Ball Corp	Bond	133,000	4.875	03/15/26	135,643	132,420
	Brunswick Corp	Bond	149,000	2.429	08/18/31	112,327	122,065
	CDW LLC/CDW Finance	Bond	136,000	3.276	12/01/28	121,530	126,515
	Centene Corp	Bond	130,000	4.250	12/15/27	127,345	125,931
	Central Garden & Pet Co	Bond	134,000	4.125	10/15/30	122,120	120,349
	Charter Comm opt LLC/CAP	Bond	120,000	3.750	02/15/28	114,044	114,301
	CON-WAY Inc	Bond	103,000	6.700	05/01/34	108,275	107,286
	Crown Amer/Cap Corp V	Bond	184,000	4.250	09/30/26	180,158	179,470
	Crown Amer/Cap Corp VI	Bond	12,000	4.750	02/01/26	11,966	11,869
	Dell Computer Corp	Bond	45,000	7.100	04/15/28	54,252	47,930
	Diamondback Energy Inc	Bond	113,000	3.500	12/01/29	111,532	105,097
	Dick's Sporting Goods	Bond	77,000	3.150	01/15/32	63,847	67,432
	Dick's Sporting Goods	Bond	39,000	4.100	01/15/52	26,408	28,491
	Discovery Communications	Bond	93,000	3.625	05/15/30	81,207	82,733
	Enlink Midstream Partner	Bond	109,000	4.850	07/15/26	108,886	108,769
	Ford Motor Company	Bond	50,000	4.346	12/08/26	48,542	49,214
	Ford Motor Company	Bond	64,000	5.291	12/08/46	62,456	54,813
	Freeport-McMoRan Inc	Bond	100,000	5.400	11/14/34	104,545	98,888
	Goodyear Tire & Rubber	Bond	155,000	4.875	03/15/27	151,929	149,755
	Griffon Corp	Bond	125,000	5.750	03/01/28	120,010	122,571
	HCA Inc	Bond	125,000	3.500	09/01/30	115,218	113,525
	Hexcel Corp	Bond	163,000	3.950	02/15/27	159,805	159,308
	Host Hotels & Resorts LP	Bond	150,000	2.900	12/15/31	122,176	127,628
	IIP Operating Partner	Bond	167,000	5.500	05/25/26	160,028	162,757
	KB Home	Bond	124,000	6.875	06/15/27	132,190	126,625
	Kraft Foods Group Inc	Bond	35,000	6.875	01/26/39	41,860	38,593
	L Brands Inc	Bond	130,000	5.250	02/01/28	125,920	127,992
	Lamar Media Corp	Bond	60,000	3.750	02/15/28	57,382	56,267
	Lamar Media Corp	Bond	124,000	4.875	01/15/29	120,442	119,125
	NRG Energy Inc	Bond	159,000	5.750	01/15/28	159,222	158,431
	Occidental Petroleum Cor	Bond	140,000	7.875	09/15/31	165,213	154,945

(a)	(b)	(c) Description of Investment Including Maturity Date, Rate of interest, Collateral, Par or Maturity Value			(d)	(e)
	Issuer, Borrower	Type	Shares/ Principal	Interest Rate / Maturity Date	Cost	Current Value
	Corporate obligations (continued):					
	Olin Corp	Bond	55,000	5.125 % 09/15/27	$ 55,281	$ 53,829
	Olin Corp	Bond	90,000	5.000 02/01/30	86,014	84,493
	PG&E Corp	Bond	69,000	5.000 07/01/28	67,171	67,409
	PG&E Corp	Bond	96,000	5.250 07/01/30	88,429	93,968
	QORVO Inc	Bond	109,000	4.375 10/15/29	105,167	102,223
	QVC Inc	Bond	126,000	4.750 02/15/27	101,829	113,400
	Range Resources Corp	Bond	161,000	8.250 01/15/29	166,136	165,766
	SBA Communications Corp	Bond	130,000	3.875 02/15/27	126,468	124,452
	Scotts Miracle-Gro Co	Bond	22,000	5.250 12/15/26	23,076	21,576
	Scotts Miracle-Gro Co	Bond	105,000	4.500 10/15/29	98,383	96,739
	Service Corp Intl	Bond	155,000	4.625 12/15/27	152,529	150,823
	Silgan Holdings Inc	Bond	115,000	4.125 02/01/28	111,246	109,757
	Six Flags Entertainment Corp	Bond	40,000	5.375 04/15/27	38,808	39,575
	Six Flags Entertainment Corp	Bond	110,000	5.250 07/15/29	101,610	105,731
	SM Energy Co.	Bond	121,000	6.500 07/15/28	118,400	120,241
	Teleflex Inc.	Bond	165,000	4.625 11/15/27	162,731	159,895
	Teva Pharma	Bond	132,000	3.150 10/01/26	121,853	126,839
	T-Mobile USA Inc	Bond	51,000	4.750 02/01/28	53,865	50,682
	United Rentals North AM	Bond	145,000	4.875 01/15/28	144,736	141,118
	United Rentals North AM	Bond	4,000	3.875 02/15/31	35,764	35,734
	Vici Properties LP	Bond	175,000	4.750 02/15/28	171,936	173,528
	Western Gas Partners LP	Bond	127,000	4.650 07/01/26	123,072	126,338
	YUM! Brands Inc	Bond	139,000	3.625 03/15/31	119,685	122,884
		Total corporate obligations			6,077,837	6,071,955
	Limited partnership - real estate:					
	Boyd Watterson State Government Fund LP		1,892		2,208,914	1,881,531
	Fixed income mutual funds:					
	Baird Intermediate Bond Fund		864,376		30,276,845	29,461,192
	Chartwell Short Duration High Yield Fund Class I		783,865		13,703,821	13,734,924
		Total fixed income mutual funds			43,980,666	43,196,116
	Equity mutual fund:					
	Fidelity 500 Index Fund Class AI #2328		20,253		3,520,072	5,280,194
	Money market mutual fund:					
*	Allspring Government Money Market Fund		8,460,657		8,460,657	8,460,657
				Total investments	$ 64,248,146	$ 64,890,453

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

Benefit Fund for Hospital and Health Care Employees - Philadelphia and Vicinity

Schedule of Reportable Transactions

Year Ended December 31, 2024

Schedule H, Line 4j

EIN: 23-2627428
Plan No: 001

(a)	(b) Description	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset	(i) Net Gain (Loss) on Transaction
*	Allspring Government Money Market	$ 37,557,086	N/A	$ 37,557,086	$ 37,557,086	N/A
		N/A	$ 45,762,712	45,762,712	45,762,712	$ -
	Baird Intermediate Bond Fund	10,347,018	N/A	10,347,018	10,347,018	N/A
	Chartwell Short Duration High Yield Fund Class I	5,061,995	N/A	5,061,995	5,061,995	N/A

* 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

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.)

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 ▶ [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
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/1992

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)
BENEFIT FUND FOR HOSPITAL AND HEALTH CARE EMPLOYEES PHILADELPHIA AND VICINITY

1319 LOCUST STREET

PHILADELPHIA PA 19107

2b Employer Identification Number (EIN) 23-2627429

2c Plan Sponsor's telephone number 215-735-5720

2d Business code (see instructions) 622000

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

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

SIGN HERE	X Dionne Gary	10/15/2025	DIONNE GARY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] 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**	2,796
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	**6a(1)**	1,424
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	1,287
b	Retired or separated participants receiving benefits	**6b**	1,325
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	2,612
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g (1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	15

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 4D 4E 4F 4K 4L 4Q 4U

9a Plan funding arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS