

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

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

Part II Basic Plan Information—enter all requested information

1a Name of plan: CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 02/01/1951
2a Plan sponsor's name (employer, if for a single-employer plan): BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND
2b Employer Identification Number (EIN): 36-2187389
2c Plan Sponsor's telephone number: 312-738-1350
2d Business code (see instructions): 424400

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

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

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include Howard Murdoch (plan administrator) and Ronald Sandack (employer/plan sponsor).

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1435
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1435
	6a(2)	1462
	6b	
	6c	
	6d	1462
	6e	
	6f	1462
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	42

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p>A Name of plan CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2187389</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
DEARBORN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2598882	71129	F019626	3431	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
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(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	

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	125898
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p>A Name of plan CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2187389</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
20-0891619	12516	30017272	1474	02/01/2024	01/31/2025

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	335610
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p>A Name of plan CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2187389</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL OF ILLINOIS

(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
36-2612058	47589	11514	1462	02/01/2024	01/31/2025

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	62154
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

A Name of plan CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 36-2187389	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

FIDELITY **P.O. BOX 770001**
CINCINNATI, OH 45277

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

BAIRD ADVISORS

39-6037917

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

NEWTOWER TRUST COMPANY

30-0872552

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

STOCKBRIDGE **4 EMBARCADERO CENTER, SUITE 3300**
SAN FRANCISCO, CA 94111

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

BENEFIT TRUST COMPANY

5901 COLLEGE BLVD., SUITE 100
OVERLAND PARK, KS 66211

(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

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)

BLUE CROSS BLUE SHIELD

36-1236610

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 73	NONE	625438	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DEIDRE JACKSON

36-2187389

(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	141877	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

THE SEGAL COMPANY

13-1975125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	132274	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LANER MUCHIN

36-3088463

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	112611	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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	NONE	103741	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VALENZ CARE

36-4869660

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	61937	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

NATIONAL INVESTMENT SERVICES

84-3937993

(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	96792	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EMMA REINKE

36-2187389

(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	95614	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LAURA CABALLERO

36-2187389

(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	93583	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LEGACY PROFESSIONALS LLP

32-0043599

(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 15	NONE	81410	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DOWD BLOCH & BENNETT

36-3371377

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	59325	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DENISE LUKASZEWSKI

36-2187389

(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	42575	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

THOMAS STIEDE

36-2187389

(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	27507	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STRATEGIC CAPITAL

36-4268991

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	NONE	20000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LASALLE CONSULTING PARTNERS, INC

36-4030449

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	19668	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

COMERICA BANK

42-1741646

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 49 59 62 72	NONE	10000	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GREEN LIGHT

45-5248276

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	NONE	9680	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

OPTUM RX

33-0441200

(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 62	NONE	7232	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

MICHAEL G. PHILIPP P.C.

36-2187389

(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?
24	TRUSTEE	6985	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GALLAGHER

12000 S. HARLEM AVE
PALOS HEIGHTS, IL 60463

(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?
55	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	5675	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(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
VALENZ CARE 36-4869660	16	DID NOT RESPOND TO THE PLAN'S MULTIPLE REQUESTS FOR INFORMATION REGARDING INDIRECT COMPENSATION RECEIVED.

(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 D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

A Name of plan <u>CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND</u>	D Employer Identification Number (EIN) <u>36-2187389</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
---------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS HIGH YIELD FUND</u>		
b Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES OF AMERICA, LLC</u>		
c EIN-PN <u>39-2021943-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1503774</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS INTERMEDIATE FIXED INCOME QP FU</u>		
b Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES OF AMERICA, LLC</u>		
c EIN-PN <u>82-4087168-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>23183351</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS TOTAL ABSOLUTE RETURN QP FUND</u>		
b Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES OF AMERICA, LLC</u>		
c EIN-PN <u>82-4069919-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>2407219</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>US CORE PARTNERS COLLECTIVE TRUST</u>		
b Name of sponsor of entity listed in (a): <u>BENEFIT TRUST COMPANY</u>		
c EIN-PN <u>87-6914227-341</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>2209425</u>
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025	
A Name of plan CHICAGO AREA IB OF T HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF CHICAGO AREA IB OF T HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 36-2187389

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

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	289905	-7836
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1669367	1801910
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	884303	1131891
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	285703	2713337
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	9992515	8635503
(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)	26779136	29303769
(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)	56164798	62448821
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	72600	68576
f Total assets (add all amounts in lines 1a through 1e).....	1f	96138327	106095971
Liabilities			
g Benefit claims payable.....	1g	1721752	3884027
h Operating payables.....	1h	82870	102142
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	50138	40322
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	1854760	4026491
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	94283567	102069480

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)	20929619	
(B) Participants.....	2a(1)(B)	114537	
(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)		21044156
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	57912	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		57912
(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)	1496952	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1496952
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	6722505	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	6721073	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		1432
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	-185976	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		-185976

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		1274633
(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)		7487071
c Other income	2c		80389
d Total income. Add all income amounts in column (b) and enter total	2d		31256569

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	21203089	
(2) To insurance carriers for the provision of benefits	2e(2)	126048	
(3) Other	2e(3)	776946	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		22106083
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)	413558	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	11810	
(4) IQPA audit fees	2i(4)	69600	
(5) Investment advisory and investment management fees	2i(5)	116792	
(6) Bank or trust company trustee/custodial fees	2i(6)	10000	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	171936	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	17242	
(11) Other expenses	2i(11)	553635	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1364573
j Total expenses. Add all expense amounts in column (b) and enter total	2j		23470656

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		7785913
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: LEGACY PROFESSIONALS LLP

(2) EIN: 32-0043599

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Financial Statements

January 31, 2025

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Financial Statements with Supplementary Information

January 31, 2025 and 2024

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	Schedule
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Report of Independent Auditors

To the Participants and Trustees of
Chicago Area I.B. of T.
Health and Welfare Trust Fund

Opinion

We have audited the financial statements of Chicago Area I.B. of T. Health and Welfare Trust Fund (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 January 31, 2025 and 2024, 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 Chicago Area I.B. of T. Health and Welfare Trust Fund as of January 31, 2025 and 2024, 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 *Auditors' 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 within one year after the date that the financial statements are available to be issued.

Responsibilities of Management for the Financial Statements (continued)

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.

Auditors' 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 auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with 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; and
- 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.

Legacy Professionals LLP

Westchester, Illinois

September 24, 2025

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Statements of Net Assets Available for Benefits

January 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Assets		
Cash	\$ 1,883,160	\$ 289,905
Receivables		
Employer contributions	1,801,910	1,669,367
Due from related organizations - net	11,781	4,810
Prescription drug rebates	<u>975,000</u>	<u>770,000</u>
Total receivables	<u>2,788,691</u>	<u>2,444,177</u>
Investments - at fair value		
Mutual funds	62,448,821	56,164,798
Pooled funds	29,303,769	26,779,136
Real estate investment funds	8,635,503	9,992,515
Cash and cash equivalents	<u>822,341</u>	<u>285,703</u>
Total investments	<u>101,210,434</u>	<u>93,222,152</u>
Property and equipment - net	<u>68,576</u>	<u>72,600</u>
Prepaid expenses and deposit	<u>145,110</u>	<u>109,493</u>
Total assets	<u>106,095,971</u>	<u>96,138,327</u>
Liabilities and Net Assets		
Liabilities		
Accounts payable	102,142	82,870
Leasehold refurbishment allowance - net	29,242	38,015
Deferred contribution income	<u>11,080</u>	<u>12,123</u>
Total liabilities	<u>142,464</u>	<u>133,008</u>
Net assets available for benefits	<u>\$ 105,953,507</u>	<u>\$ 96,005,319</u>

See accompanying notes to financial statements.

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Statements of Changes in Net Assets Available for Benefits

Years Ended January 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Additions		
Investment income		
Net appreciation in fair value of investments	\$ 8,577,160	\$ 4,709,598
Interest, dividends and other investment income	<u>1,554,864</u>	<u>1,154,523</u>
	10,132,024	5,864,121
Less investment fees	<u>(126,792)</u>	<u>(118,088)</u>
Investment income - net	<u>10,005,232</u>	<u>5,746,033</u>
Contribution income		
Employers	20,929,619	19,510,031
Participants	<u>114,537</u>	<u>103,876</u>
Total contribution income	<u>21,044,156</u>	<u>19,613,907</u>
Other income	<u>80,389</u>	<u>7,429</u>
Total additions	<u>31,129,777</u>	<u>25,367,369</u>
Deductions		
Cost of benefits		
Self-funded benefits		
Medical - net	13,713,684	14,108,407
Prescription drug - net	3,692,587	3,173,076
Dental	1,178,111	1,133,649
Vision	307,316	260,747
Disability	144,098	100,678
Flexible spending account	<u>5,018</u>	<u>14,051</u>
Total self-funded benefits	<u>19,040,814</u>	<u>18,790,608</u>
Group insurance premiums		
Life	117,038	98,185
AD&D	<u>9,010</u>	<u>8,890</u>
Total group insurance premiums	<u>126,048</u>	<u>107,075</u>
Benefit administration fees		
Network provider fees	721,474	759,143
Large case management fees	19,312	18,312
Utilization review fees	<u>36,160</u>	<u>34,130</u>
Total benefit administration fees	<u>776,946</u>	<u>811,585</u>
Total cost of benefits	19,943,808	19,709,268
Fees mandated by ACA	11,557	11,016
Administrative expenses	<u>1,226,224</u>	<u>1,121,770</u>
Total deductions	<u>21,181,589</u>	<u>20,842,054</u>
Net increase	9,948,188	4,525,315
Net assets available for benefits		
Beginning of year	<u>96,005,319</u>	<u>91,480,004</u>
End of year	<u>\$ 105,953,507</u>	<u>\$ 96,005,319</u>

See accompanying notes to financial statements.

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Statements of Benefit Obligations

January 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Amounts currently payable		
Claims payable and claims incurred but not reported	<u>\$ 3,881,300</u>	<u>\$ 1,717,600</u>

See accompanying notes to financial statements.

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Statements of Changes in Benefit Obligations

Years Ended January 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Amounts currently payable		
Balance at beginning of year	\$ 1,717,600	\$ 1,942,800
Increase (decrease) during the year attributable to changes in		
Claims payable and claims incurred but not reported	<u>2,163,700</u>	<u>(225,200)</u>
Balance at end of year	<u>\$ 3,881,300</u>	<u>\$ 1,717,600</u>

See accompanying notes to financial statements.

**Chicago Area I.B. of T.
Health and Welfare Trust Fund**

Notes to Financial Statements

January 31, 2025 and 2024

Note 1. Summary of Significant Accounting Policies

Method of Accounting - The accompanying financial statements of Chicago Area I.B. of T. Health and Welfare Trust Fund (the Plan) have been prepared using the accrual basis of accounting.

Investments - The investments of the Plan are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price). Net appreciation or depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Purchases and sales of the investments are reflected on a trade-date basis.

Dividend income is recorded on the ex-dividend date. Interest income is recorded on the accrual basis.

Employer Contributions Receivable - Employer contributions due and not paid prior to year end are recorded as contributions receivable. Employer contributions owed as a result of payroll compliance audits are recorded upon settlement with the employer. An allowance for uncollectible accounts is considered unnecessary and is not provided.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Office equipment is depreciated by the straight-line method over the estimated useful life of the asset. Amortization of leasehold improvements is computed by the straight-line method over the term of the lease. Estimated useful lives are as follows:

Office equipment	5 years
Leasehold improvements	5 years

Deferred Contribution Income - Certain participants make contributions to receive benefits under the Plan. Contributions received in advance of the corresponding eligibility period are recognized as deferred income.

Note 1. Summary of Significant Accounting Policies (continued)

Revenue Recognition - Revenue derived from employer contributions is recognized in the period in which covered work is performed, based on the number of participants covered and the contribution rate currently in effect, as set forth in the applicable collective bargaining agreement. Employers are required to remit contributions monthly. The Plan carries out its purpose described in Note 2 across Chicago and northern Illinois.

Prescription Drug Rebates - The Plan utilizes a pharmacy benefit manager (PBM) who periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable. Prescription drug rebates of \$1,631,098 and \$1,451,614 have been netted with prescription drug benefits paid for the years ended January 31, 2025 and 2024 respectively.

Subrogation Income - Claims that are reimbursed pursuant to subrogation matters are recorded upon settlement. Subrogation matters involved third parties considered to be responsible for claims paid by the Plan from whom the Plan seeks reimbursement. Medical benefits paid are shown net of subrogation refunds of \$54,018 and \$92,201 for the years ended January 31, 2025 and 2024, respectively.

Benefit Obligations - Benefit obligations are estimated by the Plan's consultant using accepted actuarial principles, based on paid and incurred claim cost studies, Plan benefits and other data as considered necessary.

Flexible Spending Accounts - Included in the Plan's net assets available for benefits are flexible spending accounts, which represent amounts available to reimburse participants for qualifying medical expenses. Claims payable from the flexible spending accounts are not included in the statements of benefit obligations. Total claims payable from the flexible spending accounts at January 31, 2025 and 2024, were \$2,727 and \$4,152 respectively. At January 31, 2025 and 2024 net assets available for benefits included flexible spending accounts totaling \$525,233 and \$567,854 respectively.

Leases - Arrangements for shared office space with related parties are described in Note 11. Due to the immaterial nature of the amounts owed pursuant to the leasing agreement, as well as the Plan not being signatory to the lease agreement, the Plan has not adopted the provisions of accounting guidance for leases required by generally accepted accounting principles. However, the Plan has included informative disclosures about the Plan's operating lease, including relevant terms, monthly lease payments and the undiscounted cash flows on an annual basis for the remaining years of the lease term.

Expenses - Certain investment related expenses are included in net appreciation in fair value of investments.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles 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.

Note 1. Summary of Significant Accounting Policies (continued)

Subsequent Events - Subsequent events have been evaluated through September 24, 2025, which is the date the financial statements were available to be issued.

Note 2. Description of the Plan

The Plan was established during 1951 under the terms of a collective bargaining agreement between Produce Drivers and Florists Union Local 703 (the Union) and Market Service Association, an association of fresh fruit, vegetable and produce dealers. The Plan is a multiemployer welfare plan subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan was established to provide eligible participants with comprehensive major medical, dental, vision and accidental death and dismemberment benefits. In addition, eligible participants are provided with group life insurance, prescription drug, hearing care and short-term disability benefits. The Trustees determine the type and amount of benefits.

To become initially eligible for benefits, a participant must be employed by a contributing employer in the collective bargaining unit represented by the Union or by an employer with a participation agreement in effect. Generally, eligibility for benefits starts as of the first day of the month following the completion of a probationary period, as defined by the Plan. Eligibility continues for each successive month that contributions are made on a participant's behalf.

The Plan provides benefits for life insurance and accidental death and dismemberment through an insurance arrangement with Dearborn. The Plan is self-insured for comprehensive major medical, prescription drug, disability, dental, vision and hearing care benefits. Blue Cross Blue Shield of Illinois is the Plan's PPO provider.

The Plan established a flexible spending account for eligible participants, to which contributions ceased effective January 1, 2016. Although contributions to the flexible spending accounts ceased, balances continue to be available to participants. A participant's account may be used to pay certain qualifying healthcare expenses not otherwise payable under the plan of benefits. The benefit to which a participant is entitled is the benefit that can be provided from the participant's flexible spending account. The unused amounts accumulated in the participant's flexible spending account may be used for future periods until exhausted, if the participant maintains eligibility. When a participant loses eligibility for coverage under the Plan, the remaining flexible spending account balance is forfeited. Forfeitures from flexible spending accounts totaled \$36,034 and \$25,822 for the years ended January 31, 2025 and 2024, respectively.

Continuation of health care benefits to persons who would otherwise lose those benefits due to certain events, as mandated by Consolidated Omnibus Budget Reconciliation Act (COBRA), was adopted by the Plan.

Participants should refer to the summary plan description for more complete information.

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's notice of exemption is dated June 25, 1963, in which the Internal Revenue Service stated that the trust established under the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the notice of exemption. The Plan's administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. They therefore believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require the Plan 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 tax authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Note 5. Fair Value Measurements

The *Fair Value Measurements and Disclosures* Topic of the FASB Accounting Standards Codification established 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 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The following describes the three levels of the fair value hierarchy:

Basis of Fair Value Measurement

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities
Level 2	Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly
Level 3	Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable

Note 5. Fair Value Measurements (continued)

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

The following tables set forth, by level within the fair value hierarchy, the Plan's investment assets at fair value as of January 31, 2025 and 2024. As required, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. In accordance with generally accepted accounting principles, 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 the following tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

	<u>Total</u>	<u>Fair Value Measurements at 1/31/25 Using</u>		
		<u>Quoted Prices</u> in Active Markets for Identical Assets (Level 1)	<u>Significant</u> Other Observable Inputs (Level 2)	<u>Significant</u> Unobservable Inputs (Level 3)
Mutual funds	\$ 62,448,821	\$ 62,448,821	\$ -	\$ -
Cash and cash equivalents	822,341	-	822,341	-
	<u>63,271,162</u>	<u>\$ 62,448,821</u>	<u>\$ 822,341</u>	<u>\$ -</u>
Investments measured at net asset value:				
Pooled funds	29,303,769			
Real estate investment funds	8,635,503			
Total	<u>\$ 101,210,434</u>			

	<u>Total</u>	<u>Fair Value Measurements at 1/31/24 Using</u>		
		<u>Quoted Prices</u> in Active Markets for Identical Assets (Level 1)	<u>Significant</u> Other Observable Inputs (Level 2)	<u>Significant</u> Unobservable Inputs (Level 3)
Mutual funds	\$ 56,164,798	\$ 56,164,798	\$ -	\$ -
Cash and cash equivalents	285,703	-	285,703	-
	<u>56,450,501</u>	<u>\$ 56,164,798</u>	<u>\$ 285,703</u>	<u>\$ -</u>
Investments measured at net asset value:				
Pooled funds	26,779,136			
Real estate investment funds	9,992,515			
Total	<u>\$ 93,222,152</u>			

Note 5. Fair Value Measurements (continued)

Level 1 Measurements

The fair values of the mutual funds are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value as of the last business day of each period presented.

Level 2 Measurements

Cash and cash equivalents are valued at cost, which approximates their fair value.

Measurements Using Net Asset Value as a Practical Expedient

Certain investments are valued at the net asset value per share, used as a practical expedient to estimate fair value. The net asset value is based on the fair values of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported net asset value.

The pooled funds are considered to be direct filing entities (DFEs) and file a Form 5500 annual report with the U.S. Department of Labor. The Plan is not required to disclose the significant investment strategies of DFE investments. There are no significant withdrawal restrictions imposed on these funds.

The underlying assets of the real estate investment funds consist of diversified, low-leveraged portfolios of institutional-quality real estate assets in the United States. Redemptions from the real estate investment funds are available on a quarterly basis following a 45-day notice period, subject to the availability of cash for distribution.

Note 6. Risks and Uncertainties

Benefit obligations are estimated based on paid and incurred claims cost studies, Plan benefits, claims experience and other data as considered necessary. Due to uncertainties inherent in the estimates and assumptions process, it is at least reasonably possible that changes in these estimates in the near term would be material to the financial statements.

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

Note 6. Risks and Uncertainties (continued)

Due to inherent uncertainties involved on the valuations of investments that are not publicly traded, estimated fair values may differ materially from the values that would have been used had a ready market for the underlying securities existed.

Real estate investment funds use interest rate swaps and caps in order to reduce the effect of interest rate fluctuations of certain real estate investments' interest expense on variable rate debt. The estimated fair values of these funds, as determined by the investment manager, may vary significantly from the prices at which the real estate investments within the fund would sell, and the amounts could be material.

Three investment funds represented approximately 81% and 79% of the Plan's net assets available for benefits as of January 31, 2025 and 2024, respectively. It is reasonably possible that changes in the fair values of these investment funds could materially affect the amounts reported in the statements of net assets available for benefits. The Plan's exposure to a concentration of credit risk is limited by the diversification of investments within each investment fund into varied financial instruments.

Note 7. Property and Equipment

Property and equipment at January 31, 2025 and 2024, consisted of the following:

	<u>2025</u>	<u>2024</u>
Office equipment	\$ 130,741	\$ 136,001
Leasehold improvements	<u>47,519</u>	<u>47,519</u>
	178,260	183,520
Less accumulated depreciation and amortization	<u>(109,684)</u>	<u>(110,920)</u>
Net property and equipment	<u>\$ 68,576</u>	<u>\$ 72,600</u>

Depreciation and amortization expense for the year ended January 31, 2025 was \$9,853 and \$9,768 for 2024.

Note 8. Concentration of Cash

Cash consists of monies held in checking accounts without significant withdrawal restrictions. The Plan places its cash with financial institutions deemed to be creditworthy. Balances are insured by the FDIC up to \$250,000 per financial institution. Although balances may at times exceed insured limits, the Plan believes its credit risk to be minimal.

Note 9. Related Organizations

The Plan is related through common governance to several entities which include three pension plans, a severance plan and the Union, all of which are tax-exempt.

Note 9. Related Organizations (continued)

The Plan shares facilities, equipment and staff with its related organizations. Certain common administrative expenses incurred among the related organizations are initially paid by the Plan and the Union and are allocated based on estimates of time spent and costs incurred. The following amounts are due (to) from the Plan as of January 31, 2025 and 2024:

	<u>2025</u>	<u>2024</u>
Chicago Area I.B. of T. Pension Trust Fund	\$ 115	\$ 14,369
Produce Drivers and Florists Union Local No. 703	(8,078)	(21,200)
Chicago Area I.B. of T. Severance and Retirement Trust Fund	<u>19,744</u>	<u>11,641</u>
Due from related organizations - net	<u>\$ 11,781</u>	<u>\$ 4,810</u>

The Plan incurred a total of \$549,770 and \$541,021 for the years ended January 31, 2025 and 2024 respectively, for its share of common administrative expenses.

Note 10. Participation in Multiemployer Plans

Defined Benefit Pension Plan

All of the Plan’s shared full-time employees are covered by a multiemployer defined benefit pension plan. The risk of participating in a multiemployer defined benefit pension plan is different from a single employer plan. Assets contributed to a multiemployer defined benefit pension plan by one employer may be used to provide benefits to employees of other participating employers. If a participating employer stops contributing to a multiemployer defined benefit pension plan, the unfunded obligations of that plan may be borne by the remaining participating employers.

The Plan’s shared participation in the multiemployer defined benefit pension plan for the years ended January 31, 2025 and 2024 is outlined in the following table. A plan that is considered to be significant is required to be identified. The “EIN/PN” column provides the employer identification number (EIN) and the three-digit plan number (PN). The most recent Pension Protection Act (PPA) zone status provides an indication of the financial health of the plan. Among other factors, plans in the red zone status are below 65 percent funded, plans in the yellow zone are between 65 and 80 percent funded, and plans in the green zone are at least 80 percent funded. The last column specifies the year end date of the plan to which the annual report (Form 5500) relates.

<u>Pension Plan</u>	<u>EIN/PN</u>	<u>Pension Protection Act Zone Status</u>		<u>Contributions</u>		<u>Most Recently Available Annual Report (Form 5500)</u>
		<u>2025</u>	<u>2024</u>	<u>2025</u>	<u>2024</u>	
Chicago Area I.B. of T. Pension Trust Fund	36-2407063/001	Green as of 2/1/25	Green as of 2/1/24	\$ 121,821	\$ 122,081	1/31/2024

Note 10. Participation in Multiemployer Plans (continued)

Defined Benefit Pension Plan (continued)

Contributions are made monthly under the terms of a participation agreement, which does not have an expiration date. The Plan's contributions do not represent more than 5% of total contributions to this plan as indicated in the plan's most recently available annual report. Contribution amounts represent the total contributions made prior to the allocation of common administrative expenses to related organizations described in Note 9.

Defined Contribution Retirement Plan

All full-time employees are also covered by a multiemployer defined contribution retirement plan. Contributions to the plan for the years ended January 31, 2025 and 2024 totaled \$55,080 and \$57,845 respectively. Contribution amounts represent the total contributions made prior to the allocation of common administrative expenses to related organizations described in Note 9.

Note 11. Leasing Arrangements

The Plan shares office space with various related organizations. The lease agreement entered into by the Union was set to expire on September 14, 2022. In June 2021, the lease was extended for an additional period of five years through June 14, 2028, with rent abated for the first nine months. The lease also called for a refurbishment allowance not to exceed \$215,775 to be applied towards the payment of leasehold improvements. The Plan's portion of the leasehold refurbishment allowance totaled \$47,519. The Plan's allocated portion of lease payments is determined annually based on the square footage of the respective office space utilized.

At January 31, 2025, the Plan's share of future minimum rental payments required under this operating lease is as follows:

Year ending January 31,	
2026	\$ 61,850
2027	63,394
2028	64,988
2029	<u>21,975</u>
Total	<u>\$ 212,207</u>

The Plan's allocated portion of rent expense was \$57,080 and \$21,144 during the years ended January 31, 2025 and 2024, respectively.

The Union also entered into agreements for the rental of shared office equipment. The Plan's allocated portion of lease payments is determined on an annual basis based on utilization.

Note 12. Funding Policy

The Plan is primarily funded by employer contributions and from participants electing COBRA coverage. The participating employers contribute amounts as are required under their collective bargaining agreements. The monthly contribution rates vary based on plan participation. The majority of the employers' rates ranged from \$1,110 to \$1,295 per month for the years ended January 31, 2025 and 2024.

Participants are allowed to self-pay contributions to extend eligibility for benefit coverage. Participant contribution rates are determined annually based on claims experience. For the years ended January 31, 2025 and 2024, monthly COBRA contribution rates ranged from \$1,347 to \$2,037 depending on the coverage option selected.

Note 13. Major Employers

Contributions from three employers accounted for approximately 46% of total contributions received during each of the years ended January 31, 2025 and 2024. If the employers were to suspend contributions, the Plan would terminate coverage to the employers' participants as required under the Plan document. The Plan would also retain the risk of meeting current fixed administrative expenses until the appropriate adjustments are made.

Note 14. Reconciliation of Financial Statements to Form 5500

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

	<u>2025</u>	<u>2024</u>
Net assets available for benefits per the financial statements	\$ 105,953,507	\$ 96,005,319
Less - benefit obligations currently payable at end of year	(3,881,300)	(1,717,600)
Less - flexible spending account claims payable at end of year	<u>(2,727)</u>	<u>(4,152)</u>
Net assets available for benefits per the Form 5500	<u>\$ 102,069,480</u>	<u>\$ 94,283,567</u>

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500 for the year ended January 31, 2025:

Benefits paid to or for participants per the financial statements	\$ 19,943,808
Add - amounts currently payable at end of year	3,881,300
Add - flexible spending account claims payable at end of year	2,727
Less - amounts currently payable at beginning of year	(1,717,600)
Less - flexible spending account claims payable at beginning of year	<u>(4,152)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 22,106,083</u>

Amounts allocated to participants requesting withdrawals from their flexible spending accounts are recorded on the Form 5500 for benefit claims that have been processed and approved for payment prior to year end, but not yet paid as of that date.

Report of Independent Auditors On Supplemental Schedules

To the Participants and Trustees of
Chicago Area I.B. of T.
Health and Welfare Trust Fund

We have audited the financial statements of Chicago Area I.B. of T. Health and Welfare Trust Fund (the Plan) as of and for the years ended January 31, 2025 and 2024, and our report thereon dated September 24, 2025, which expressed an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. Supplemental Schedules 1 and 2 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the 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 schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

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

Legacy Professionals LLP

Westchester, Illinois

September 24, 2025

Chicago Area I.B. of T. Health and Welfare Plan
Schedule of Asset Held
Y/E 01/31/2025

Security Description	Cost	Fair Value
Common & Collective Trust		
NIS High Yield Fund LLC	1,022,237	1,503,774
NIS Intermediate Fixed Income QP Fund LLC	22,621,675	23,183,351
NIS Total Absolute Return QP Fund LLC	2,109,412	2,407,219
U.S. Core Partners Collective Investment Trust	2,500,000	2,209,425
		<u>29,303,769</u>
Partnership		
BGO Diversified US Property Fund LP	3,570,531	5,017,231
Stockbridge Niche Logistics Fund, LP	2,416,544	2,538,985
Stockbridge Smart Markets Fund, LP	2,155,363	1,079,287
		<u>8,635,503</u>
Registered Investment Companies		
Baird Intermediate Bond Inst CL	27,062,065	27,035,196
Fidelity Total Market Index Fund	28,450,179	35,413,625
		<u>62,448,821</u>
Interest Bearing Cash		
Short-term investment fund	822,341	822,341
Short-term investment fund	1,890,996	1,890,996
		<u>2,713,337</u>



5% Transactions - By Issue
For the Period February 01, 2024 - January 31, 2025

CHICAGO AREA IB OF T H & W

Account Number: [REDACTED]

Date	Transaction	Description	EBT Cost	Market Value
CHICAGO AREA IB OF T H & W				
02/01/2024	SWEEP PURCHASE	962.54 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	962.54	962.54
03/01/2024	SWEEP PURCHASE	1,126.49 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,126.49	1,126.49
03/13/2024	SWEEP PURCHASE	2,000,000 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	2,000,000.00	2,000,000.00
03/14/2024	SWEEP SALE	2,000,000 shares GOLDMAN SACHS FIN SQ GOVT INST	2,000,000.00	2,000,000.00
03/26/2024	SWEEP SALE	200,000 shares GOLDMAN SACHS FIN SQ GOVT INST	200,000.00	200,000.00
04/01/2024	SWEEP PURCHASE	1,319.75 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,319.75	1,319.75
04/11/2024	SWEEP PURCHASE	112,676.87 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	112,676.87	112,676.87
04/17/2024	SWEEP PURCHASE	30,778.42 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	30,778.42	30,778.42
05/01/2024	SWEEP PURCHASE	763.38 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	763.38	763.38
05/01/2024	SWEEP SALE	37.21 shares GOLDMAN SACHS FIN SQ GOVT INST	37.21	37.21
05/30/2024	SWEEP SALE	150,000 shares GOLDMAN SACHS FIN SQ GOVT INST	150,000.00	150,000.00



5% Transactions - By Issue
For the Period February 01, 2024 - January 31, 2025

CHICAGO AREA IB OF T H & W
 Account Number: [REDACTED]

Date	Transaction	Description	EBT Cost	Market Value
06/03/2024	SWEEP PURCHASE	941.72 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	941.72	941.72
06/06/2024	SWEEP PURCHASE	8,249.02 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	8,249.02	8,249.02
06/28/2024	SWEEP PURCHASE	2,000,000 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	2,000,000.00	2,000,000.00
07/01/2024	SWEEP PURCHASE	1,185.94 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,185.94	1,185.94
07/01/2024	SWEEP SALE	2,000,000 shares GOLDMAN SACHS FIN SQ GOVT INST	2,000,000.00	2,000,000.00
07/12/2024	SWEEP PURCHASE	125,646.72 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	125,646.72	125,646.72
07/16/2024	SWEEP PURCHASE	46,047.51 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	46,047.51	46,047.51
07/17/2024	SWEEP PURCHASE	9,119.04 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	9,119.04	9,119.04
08/01/2024	SWEEP PURCHASE	854.72 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	854.72	854.72
09/03/2024	SWEEP PURCHASE	1,155.79 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,155.79	1,155.79



5% Transactions - By Issue
For the Period February 01, 2024 - January 31, 2025

CHICAGO AREA IB OF T H & W

Account Number: [REDACTED]

Date	Transaction	Description	EBT Cost	Market Value
10/01/2024	SWEEP PURCHASE	1,085.52 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,085.52	1,085.52
10/11/2024	SWEEP PURCHASE	17,981.96 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	17,981.96	17,981.96
10/16/2024	SWEEP PURCHASE	98,863.05 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	98,863.05	98,863.05
11/01/2024	SWEEP PURCHASE	1,315.21 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,315.21	1,315.21
12/02/2024	SWEEP PURCHASE	1,419.38 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	1,419.38	1,419.38
12/23/2024	SWEEP PURCHASE	900,000 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	900,000.00	900,000.00
12/30/2024	SWEEP SALE	1,200,000 shares GOLDMAN SACHS FIN SQ GOVT INST	1,200,000.00	1,200,000.00
01/02/2025	SWEEP PURCHASE	2,078.47 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	2,078.47	2,078.47
01/14/2025	SWEEP PURCHASE	617,242.15 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	617,242.15	617,242.15
01/16/2025	SWEEP PURCHASE	93,887.59 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	93,887.59	93,887.59



5% Transactions - By Issue
For the Period February 01, 2024 - January 31, 2025

CHICAGO AREA IB OF T H & W
 Account Number: [REDACTED]

Date	Transaction	Description	EBT Cost	Market Value
01/17/2025	SWEEP PURCHASE	11,974.86 shares GOLDMAN SACHS FIN SQ GOVT INST STATE COST: 0.00	11,974.86	11,974.86
Total			11,636,713.31	11,636,713.31
02/29/2024	SALE SETTLEMENT	2,863.688 shares FIDELITY TOTAL MARKET INDEX FUND- INS PR Trade 02/28/2024 Settle 02/28/2024 2,863.688 Units @ 139.68 Fed Long Term Gain: 59,724.74	381,471.88	400,000.00
03/13/2024	SALE SETTLEMENT	14,034.103 shares FIDELITY TOTAL MARKET INDEX FUND- INS PR Trade 03/12/2024 Settle 03/12/2024 14,034.103 Units @ 142.51 Fed Long Term Gain: 332,409.79	1,869,482.86	2,000,000.00
04/16/2024	REINVESTMENT	425.464 shares @ 0.26 FIDELITY TOTAL MARKET INDEX FUND- INS PR	59,884.03	0.00
06/28/2024	SALE SETTLEMENT	14,347.681 shares FIDELITY TOTAL MARKET INDEX FUND- INS PR Trade 06/27/2024 Settle 06/27/2024 14,347.681 Units @ 149.85 Fed Long Term Gain: 444,569.12	1,911,398.06	2,150,000.00
12/23/2024	SALE SETTLEMENT	5,533.354 shares FIDELITY TOTAL MARKET INDEX FUND- INS PR Trade 12/20/2024 Settle 12/20/2024 5,533.354 Units @ 162.65 Fed Long Term Gain: 242,280.27	737,153.42	900,000.00



5% Transactions - By Issue
For the Period February 01, 2024 - January 31, 2025

CHICAGO AREA IB OF T H & W
Account Number: [REDACTED]

Date	Transaction	Description	EBT Cost	Market Value
12/24/2024	REINVESTMENT	2,197.937 shares @ 1.652 FIDELITY TOTAL MARKET INDEX FUND- INS PR	357,494.40	0.00
Total FIDELITY			5,316,884.65	5,450,000.00
Total All Issues			16,953,597.96	17,086,713.31

FOOTNOTES

STATEMENT 1

SCHEDULE C - EMPLOYEES OF THE PLAN ARE SHARED EMPLOYEES WITH THE RELATED PENSION AND SEVERANCE PLANS AS WELL AS THE RELATED LOCAL UNION. AMOUNTS REPORTED IN BOX (D) REPRESENT THE PLANS SHARE OF TAXABLE COMPENSATION AND NON-TAXABLE EMPLOYEE BENEFITS BASED ON AN ALLOCATION APPROVED BY THE TRUSTEES. AMOUNTS REPORTED ARE DETERMINED IN ACCORDANCE WITH FORM 5500 FILING INSTRUCTIONS.

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 2

NAME	SERVICE CODES
COMERICA BANK	19
COMERICA BANK	49
COMERICA BANK	59
COMERICA BANK	62
COMERICA BANK	72

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
PRESCRIPTION REBATE	770,000.	975,000.
DUE FROM RELATED ORGANIZATION	4,810.	11,781.
PREPAID EXPENSE	109,493.	145,110.
TOTAL TO SCHEDULE H, LINE 1B(3)	884,303.	1,131,891.

SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT 4
DESCRIPTION	BEGINNING	ENDING
DEFERRED CONTRIBUTIONS	12,123.	11,080.
LEASEHOLD REFURBISHMENT ALLOWANCE	38,015.	29,242.
TOTAL TO SCHEDULE H, LINE 1J	50,138.	40,322.

SCHEDULE H	OTHER INCOME	STATEMENT 5
DESCRIPTION	AMOUNT	
MISCELLANEOUS INCOME	80,389.	
TOTAL TO SCHEDULE H, LINE 2C	80,389.	

SCHEDULE H	OTHER PAYMENTS TO PROVIDE BENEFITS	STATEMENT 6
DESCRIPTION	AMOUNT	
UTILIZATION REVIEW FEES	36,014.	
NETWORK PROVIDER FEES	721,474.	
LARGE CASE MANAGEMENT FEES	19,312.	
INDEPENDENT MEDICAL REVIEW FEES	146.	
TOTAL TO SCHEDULE H, LINE 2E(3)	776,946.	