

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <h1 style="text-align: center;">2024</h1> This Form is Open to Public Inspection
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

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

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>OHIO AFSCME CARE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>OHIO AFSCME CARE PLAN</u> <u>BOARD OF TRUSTEES</u> <u>1603 EAST 27TH STREET</u> <u>CLEVELAND, OH 44114-4217</u>	1c Effective date of plan <u>04/01/1973</u> 2b Employer Identification Number (EIN) <u>34-6726788</u> 2c Plan Sponsor's telephone number <u>216-781-6420</u> 2d Business code (see instructions) <u>525100</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	12/13/2025	SEAN GRAYSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

<p>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p>OHIO AFSCME CARE PLAN</p> <p>1603 EAST 27TH STREET CLEVELAND, OH 44114</p>	<p>3b Administrator's EIN 34-6726788</p> <p>3c Administrator's telephone number 216-781-6420</p>																				
<p>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:</p> <p>a Sponsor's name</p> <p>c Plan Name</p>	<p>4b EIN</p> <p>4d PN</p>																				
<p>5 Total number of participants at the beginning of the plan year</p>	<p>5 22607</p>																				
<p>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).</p> <p>a(1) Total number of active participants at the beginning of the plan year</p> <p>a(2) Total number of active participants at the end of the plan year</p> <p>b Retired or separated participants receiving benefits.....</p> <p>c Other retired or separated participants entitled to future benefits</p> <p>d Subtotal. Add lines 6a(2), 6b, and 6c.....</p> <p>e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.</p> <p>f Total. Add lines 6d and 6e</p> <p>g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p> <p>g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p> <p>h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:10%;">6a(1)</td><td style="width:90%;">22519</td></tr> <tr><td>6a(2)</td><td>22458</td></tr> <tr><td>6b</td><td>0</td></tr> <tr><td>6c</td><td>12</td></tr> <tr><td>6d</td><td>22470</td></tr> <tr><td>6e</td><td></td></tr> <tr><td>6f</td><td></td></tr> <tr><td>6g(1)</td><td></td></tr> <tr><td>6g(2)</td><td></td></tr> <tr><td>6h</td><td></td></tr> </table>	6a(1)	22519	6a(2)	22458	6b	0	6c	12	6d	22470	6e		6f		6g(1)		6g(2)		6h	
6a(1)	22519																				
6a(2)	22458																				
6b	0																				
6c	12																				
6d	22470																				
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
<p>7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)</p>	<p>7</p>																				

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: small;">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 style="font-size: 24pt;">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 **03/01/2024** and ending **02/28/2025**

<p>A Name of plan OHIO AFSCME CARE 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 OHIO AFSCME CARE PLAN</p>	<p>D Employer Identification Number (EIN) 34-6726788</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
MEDMUTUAL 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
21-0706531	62375	560058	12687	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.

<p>(a) Total amount of commissions paid 67977</p>	<p>(b) Total amount of fees paid</p>
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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
ONEDIGITAL EXPRESSLINK LLC **4200 ROCKSIDE RD 300**
CLEVELAND, OH 44131

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
67977		INSURANCE FEES AND COMMISSION CONSULTING	3

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

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

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	(c) Amount	(d) Purpose	

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

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

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	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)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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) ▶ **DEPENDENT LIFE, 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	1149444
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. ▶

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	4818385	
(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)		4818385
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)		3741211
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	95019	
(B) Administrative service or other fees	9c(1)(B)	450402	
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)	68513	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		613934
(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		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**

A Name of plan OHIO AFSCME CARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO AFSCME CARE PLAN	D Employer Identification Number (EIN) 34-6726788	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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)

ANGELA PLONA

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	10983	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)

RAE L BORDERS

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	19581	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)

RENEE A JOHNSON

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	66416	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)

VICKI JOHNSON

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	78539	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)

BRENDA JACKSON

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	4516	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)

STEPHANIE M BECKER

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	70174	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)

VONITA S GILBERT

1603 E 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	76363	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)

JL ASSOCIATES, INC. C/O TRAMER BOLB

23775 COMMERCE PARK STE 1
BEACHWOOD, OH 44122

34-1776903

(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?
	AUDITOR	59000	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)

JOHN FILAK

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	ADMINISTRATOR	131107	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)

WAINBLAT LAW LLC

7738 BLACKFORD DRIVE
CHAGRIN FALLS, OH 44022

85-4381750

(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	LEGAL	82544	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)

LESLIE DAVIS

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	48161	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)

MERILL LYNCH

1500 AMERICAN BLVD
PENNINGTON, NJ 08534-4129

13-5674085

(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	BROKER	27158	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)

PATRICIA HARRISON

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	70742	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)

JOLIEKA GRAHAM

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	4700	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)

RACHAEL A BERGKESSEL

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	65441	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)

LAWSON, EDDIE

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14	EMPLOYEE	141858	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)

MASTERS LISA

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	95225	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)

MOLLETT CINDY

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	62329	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)

ROCHFORD ELIZABETH C

1603 EAST 27TH STREET
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	58189	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)

ISAAC FRADETTE

1603 EAST 27TH ST
CLEVELAND, OH 44114

34-1133688

(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?
	EMPLOYEE	2470	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <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 03/01/2024 and ending 02/28/2025	
A Name of plan OHIO AFSCME CARE PLAN	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO AFSCME CARE PLAN	D Employer Identification Number (EIN) 34-6726788

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	10076614	
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	641778	734941
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		99519
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	17074780	25521782
(2) U.S. Government securities	1c(2)		3700650
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	3603766	3887663
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	3823582	4190189
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(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	140836	151794
f Total assets (add all amounts in lines 1a through 1e).....	1f	35361356	38286538
Liabilities			
g Benefit claims payable.....	1g	1396344	1746212
h Operating payables.....	1h	211055	346961
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	36800	38800
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	1644199	2131973
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	33717157	36154565

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)	19089199	
(B) Participants.....	2a(1)(B)	17454	
(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)		19106653
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	1169623	
(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)		1169623
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	842046	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		21118322

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	10289882	
(2) To insurance carriers for the provision of benefits	2e(2)	5656590	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		15946472
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)	462726	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	27157	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	82544	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	2162015	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2734442
j Total expenses. Add all expense amounts in column (b) and enter total	2j		18680914

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		2437408
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: **TRAMER & BOLBACH, INC**

(2) EIN: **34-1736265**

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

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

Part IV Compliance Questions

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

During the plan year:

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

OHIO AFSCME CARE PLAN

AUDITED FINANCIAL STATEMENTS

FEBRUARY 28, 2025 AND FEBRUARY 29, 2024

Independent Auditor's Report

To the Board of Trustees of
The Ohio AFSCME Care Plan

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Ohio AFSCME Care Plan, which comprise the statements of net assets available for benefits as of February 28, 2025 and February 29, 2024, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's responsibility for the financial statements

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

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstance, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits of Ohio AFSCME Care Plan as of February 28, 2025, and February 29, 2024, and the changes in net assets available for benefits for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Cleveland, Ohio
November 10, 2025

OHIO AFSCME CARE PLAN
 Statements of Net Assets Available for Plan Benefits & Benefit Obligations
 February 28, 2025 and February 29, 2024

	2025	2024
<u>NET ASSETS</u>		
ASSETS		
Investments, at fair value:		
Certificates of deposit	\$ 11,144,728	\$ 15,273,549
Other interest bearing investments	7,588,313	3,603,766
Common stocks and mutual funds	4,190,189	3,823,582
Money market accounts	2,936,899	1,710,463
Total investments	25,860,129	24,411,360
Receivables:		
Participating employers' contributions	734,941	641,778
Accrued Interest receivable	99,519	90,768
Total receivables	834,460	732,546
Cash	11,440,155	10,076,614
Prepaid expenses and deposits	126,377	116,350
Fixed assets, at cost	459,652	451,043
Less: accumulated depreciation and amortization	434,235	426,557
Total fixed assets, net	25,417	24,486
 TOTAL ASSETS	 38,286,538	 35,361,355
LIABILITIES		
Accounts payable for administrative expenses	19,115	5,012
Accrued expenses and withheld payroll taxes	327,846	206,043
TOTAL LIABILITIES	346,961	211,055
 NET ASSETS AVAILABLE FOR PLAN BENEFITS	 \$ 37,939,577	 \$ 35,150,301
<u>BENEFIT OBLIGATIONS</u>		
Amounts currently payable:		
Life Insurance Payable	96,212	96,344
Estimated claims incurred but not reported	1,650,000	1,300,000
	1,746,212	1,396,344
Postemployment benefit obligations, net of amounts currently payable:		
Total and permanently disabled reserve	38,800	36,800
Total benefit obligations	1,785,012	1,433,144
 EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	 \$ 36,154,565	 \$ 33,717,157

The accompanying notes are an integral part of these financial statements

OHIO AFSCME CARE PLAN
 Statements of Changes in Net Assets Available for Plan Benefits
 and Changes in Benefit Obligations
 February 28, 2025 and February 29, 2024

NET CHANGES IN NET ASSETS AVAILABLE FOR PLAN BENEFITS

	2025	2024
<u>ADDITIONS TO NET ASSETS ATTRIBUTED TO</u>		
Contributions:		
Participating employers	\$ 19,089,199	\$ 18,188,188
Other participants	17,454	20,100
Total contributions	19,106,653	18,208,288
Investment income:		
Net appreciation/(depreciation) in fair value of investments	842,046	879,014
Interest and dividends	1,169,623	930,339
	2,011,669	1,809,353
Less investment expenses	27,157	22,815
Net investment income	1,984,512	1,786,538
TOTAL ADDITIONS	21,091,165	19,994,826
<u>DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO</u>		
Cost of benefits:		
Life insurance premiums	1,150,717	1,019,815
Prescription, hearing aid programs and employee assistance programs	1,856,791	2,374,251
Eye care program	605,637	553,221
Dental claims	7,827,454	7,356,057
Medical insurance premiums	4,505,873	4,100,137
Total cost of benefits	15,946,472	15,403,481
Administrative expenses	2,707,285	2,631,046
TOTAL DEDUCTIONS	18,653,757	18,034,527
NET INCREASE DURING YEAR	2,437,408	1,960,299

The accompanying notes are an integral part of these financial statements

OHIO AFSCME CARE PLAN
 Statements of Changes in Net Assets Available for Plan Benefits
 and Changes in Benefit Obligations
 February 28, 2025 and February 29, 2024

NET CHANGES IN BENEFIT OBLIGATIONS

	2025	2024
Decrease (increase) during the year attributable to:		
Amounts currently payable		
Insurance premiums payable	131	(11,872)
Claims payable	-	-
Estimated liability for claims incurred but not reported & permanent disabled Res.	(352,000)	124,000
NET CHANGE IN BENEFIT OBLIGATIONS	\$ (351,869)	\$ 112,128
NET CHANGE IN EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	2,437,408	1,960,299
Excess of net assets available for benefits over benefit obligations:		
Beginning of year	33,717,157	31,756,858
End of year	\$ 36,154,565	\$ 33,717,157

The accompanying notes are an integral part of these financial statements

SUPPLEMENTAL INFORMATION

OHIO AFSCME CARE PLAN
Schedules of Administrative Expenses
For the Years Ended February 28, 2025 and February 29, 2024

	2025	2024
<u>ADMINISTRATIVE EXPENSES</u>		
Administrative salaries	\$ 1,025,872	\$ 989,939
Hospitalization and other employee insurance	699,422	591,759
Pension plan	163,177	152,164
Payroll taxes	81,030	77,050
PCORI fee	152,761	138,500
Rent	45,879	46,224
Telephone	24,673	27,807
Office insurance	4,753	4,425
Office supplies, fees and services	83,997	80,734
Printing - benefit booklets and forms	21,171	72,712
Postage and shipping	108,735	99,137
Office and computer equipment maintenance	70,302	68,364
Legal and consulting fees	82,544	115,493
Audit and accounting fees	59,000	59,000
Plan fiduciary liability insurance	12,771	12,760
Conference registration fees and travel expenses	48,549	50,691
Travel, inter-office	6,432	6,020
Depreciation and amortization	7,679	6,116
Dues & Subscription	3,940	9,975
Miscellaneous, net	4,598	22,176
	<u>\$ 2,707,285</u>	<u>\$ 2,631,046</u>
TOTAL ADMINISTRATIVE EXPENSES	<u>\$ 2,707,285</u>	<u>\$ 2,631,046</u>

The accompanying notes are an integral part of these financial statements

OHIO AFSCME CARE PLAN

Notes to Financial Statements

NOTE A -- DESCRIPTION OF PLAN

The following description of the Ohio AFSCME Care Plan (the Plan) provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions.

General. The Ohio AFSCME Care Plan was first established as a result of the collective bargaining agreement between the Ohio Council 8, the American Federation of State, County and Municipal Employees, the AFL-CIO and the Board of Trustees of Metro Health System. Subsequently, other hospitals, municipalities and government agencies have become participating employers. The sole purpose of the Plan is to provide health and welfare and life insurance benefits to its participants and their dependents. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan is administered by a Board of Trustees with equal representation from labor and management and is financed entirely by employer contributions for participants covered under the collective bargaining agreement. Passage of the Fifth Amendment opened up participation in the Plan to employees outside of the bargaining unit of employers already participating in the Plan for bargaining unit members. The types of benefits, which the employer has agreed to include in its collective bargaining agreement, determine the monthly employer contribution rates. Monthly contribution rates that were in effect at February 28, 2025 and February 29, 2024 ranged from \$.50 to \$225, depending on the types of benefits that are selected.

The Plan's main office is located in Cleveland, Ohio. It also has a regional office in Cincinnati which serve participating employers and their participants in those areas. Claims from the Cincinnati area are processed and paid by the Cincinnati office.

NOTE B -- SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting. The financial statements of the Plan are maintained on the accrual basis of accounting, which recognizes income in the period it is earned and expenses in the period they are incurred.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and the reported amounts of additions and deductions during the reporting period. Actual results could differ from those estimates.

Employers' Contribution Receivable. Participating employers' contributions which are due at the fiscal year-end but are received thereafter are recorded as contributions receivable. Contributions which have not been received during a reasonable period after the fiscal year-end are reasonably estimated.

NOTE B -- SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

A review is made at the fiscal year-end of the status of contributions receivable to determine their collectability. Such review, coupled with historical collection experience, serves as a basis for determining the amount required, if any, as an allowance for doubtful accounts. At February 28, 2025 and February 29, 2024 there were no allowance for doubtful accounts.

Office Furniture, Equipment and Leasehold Improvements. Fixed assets are recorded at cost less accumulated depreciation, which approximates fair value.

Depreciation of office furniture, equipment and leasehold improvements are computed on the optional straight-line method allowed by the Accelerated Cost Recovery system (ACRS) and Modified Cost Recovery System (MACRS) for assets acquired after December 31, 1980. The estimated lives used in the calculations are 3, 5, 7, 10 and 31.5 years under MACRS and 10 years for the straight-line method. One-half year's depreciation expense is taken in the year of acquisition and in the year of disposition of an asset.

Investment Valuation and Income Recognition. Investments are stated at current fair value using quoted market prices where available. Some certificates of deposit are stated at cost, which is maturity value, and which closely approximates estimated fair value. Investment transactions are recognized on the trade date, which is the date the order to buy or sell is executed. Interest income accruing on certificates of deposit and government agency obligations is recorded as interest receivable. Interest income accruing on U.S. Treasury bills is added to their cost basis, ratably, to maturity. Dividends are recorded on the ex-dividend date. Gains and losses are recognized when sold. In instances where stocks have been purchased at various times, an average cost may be used to determine the realized gain or loss.

Federal Tax-Exempt Status. The Plan is exempt from Federal income tax under Section 501(c)(9) of the Internal Revenue Code. The Plan has obtained a favorable tax determination letter from the Internal Revenue Service, and the Board of Trustees believes that the Trust, as amended, continues to qualify and to operate in accordance with applicable provisions of the Internal Revenue Code.

NOTE C -- INVESTMENTS

The Plan's investments consist of bank certificates of deposit (CD's), corporate bonds, common stocks and money market accounts. Under the Plan's investment policy as of the date of the balance sheet, individual investments in CD's, U.S. Treasury obligations and government agency obligations are limited to a maximum maturity term of fifteen years. The Plan's consistent policy since inception has been to hold all investments to their respective maturity or call dates.

In accordance with provisions of the Plan's trust agreement relating to the investments of employers' contributions, the trustees have retained Merrill Lynch, as their investment advisor for their equity portfolio. These advisors have discretionary authority to in equity investments that meet the plan's investment policy.

Merrill Lynch, under the terms of the agreement, was named the custodian of the equity investments. The custodian executes the investment decisions made by the investment advisors.

NOTE C -- INVESTMENTS (Continued)

During the plan years ending February 28, 2025 and February 29, 2024, the Plan's investments, including investments bought and sold, as well as those held during the year (depreciated) appreciated in value as indicated below:

	2025	2024
Investments at fair value as determined by quoted market price:		
Common stocks	\$ 4,190,189	\$ 3,823,582
Corporate bonds/notes	7,588,313	3,603,766
Certificates of Deposits	11,144,728	15,364,317
	<u>\$ 22,923,230</u>	<u>\$22,791,665</u>

The Plan has adopted the revised generally accepted accounting principles related to Fair Value Measurements. The Fair Value Measurements established a hierarchy that prioritizes the inputs to valuation techniques, giving the highest priority to readily available unadjusted quoted prices in active markets for identical assets (Level 1 assets) and lowest priority to unobservable inputs (level 3 assets) when market prices are not readily available or reliable. The three levels of hierarchy are described below:

Level 1 - quoted prices in active markets for identical investments

Level 2 - other significant observable inputs (including quoted prices for similar investments, interest rate, prepayment needs, credit risk, etc.)

Level 3 - significant unobservable inputs with determining the fair value of investments

The inputs or methodology used for valuing an investment are not necessarily an indication of the risk associated with investing in those securities. As of February 28, 2025 and February 29, 2024, there were no Level 3 assets associated with the Plan.

The following is a summary of the inputs used to value the Plan's investments as of February 28, 2025 and February 29, 2024:

Valuation Inputs	Investment in Securities	
	2025	2024
Level 1	\$ 4,190,189	\$ 3,823,582
Level 2	\$21,669,940	\$ 20,678,546
Total	<u>\$25,860,129</u>	<u>\$24,502,128</u>

Securities listed on a United States exchange for which market quotations are readily available are valued at the last quoted sale price as of the close of the exchange on the day the valuation is made, or if no sale occurred on such day, at the bid price on such day. Over-the-counter and unlisted securities are valued at the current bid prices. Short-term investments that have remaining maturities of sixty days or less at the time of purchase are valued at amortized cost, which approximates market value. The value of other assets and securities for which no quotations are readily available is determined in good faith at fair value using methods determined by the Investment Advisor.

NOTE D -- DESCRIPTION OF BENEFITS PROVIDED

Prescription Drug Plan Benefit. The Plan provides for regular prescription drug benefits for eligible participants and their spouses and dependent children. The Plan reimburses 90% on each prescription and limits the maximum benefit for each covered person to \$600 per calendar year.

Prescription Card Plan. On August 1, 2001, the Plan had contracted with Caremark, Inc. to allow eligible participants and their spouses and dependent children to pay a 10% co-pay amount when presenting their prescription card at specific pharmacies. Caremark pays the remaining 90% to the pharmacies. The Plan then reimburses Caremark for their portion of the prescriptions paid plus an administrative fee. The maximum prescription card benefit varies between each benefit plan created with Caremark. Both of these programs are self-funded.

Life Insurance and Accidental Death and Dismemberment Insurance Levels I and II. Coverage under Level I provides each eligible participant with life insurance ranging between \$14,000 and \$30,000 at February 28, 2025 and February 29, 2024 and a like amount of accidental death and dismemberment insurance. The exact amount of each participant's coverage depends on his current salary. In addition, spouses and dependent children over 14 days of age are provided with \$2,000 of life insurance. Level II coverage is similar to Level I with the exception that the benefit is increased to \$50,000 regardless of the participant's current salary. The life insurance benefit is underwritten entirely by MedMutual Life Insurance Company.

Dental Care Benefits Levels I-IV. The Plan provides a dental care benefit program for participants and their spouses and dependent children for those employers paying the contribution rate negotiated to include this benefit. Dental Care Benefit Level I provides dental services under a plan that pays up to a maximum allowable amount per treatment as listed in the Table of Allowances for Dental Procedures. There is no limitation on annual benefit and no deductible for services. Effective January 1, 2001, new employers will not be accepted into this level of coverage.

Dental Care Benefit Level II includes orthodontia work for dependent children who are under the age of 19 of participants covered by this plan limited to \$1,500 per year. Dental services are paid similar to Level I, except that a Table of Allowances providing higher benefits is used. The Dental Benefits Level II has a \$4,000 annual limit per participant.

Dental Care Benefit Level III provides coverage to participants and their spouses and dependent children. Level III includes orthodontia work, similar to Level II, but its limitation per year is \$2,000. Payment for dental services is based upon the lesser of the usual, customary, and reasonable (UCR) rate or the actual amount charged. The annual maximum benefit for dental services is also \$4,000 per participant per calendar year.

Dental Care Benefit Level IV is similar in all aspects to Level III, except that the usual, customary, and reasonable (UCR) rate for major restorative work is greater than that used in Level III.

Hearing Aid. The Plan provides a fully paid hearing aid program for all eligible participants and their spouses and dependent children. The program provides for the furnishing of hearing aids costing up to \$1,500 per ear, as well as the related examinations, once every 4 years. The Hearing Aid Program is self-funded.

NOTE D -- DESCRIPTION OF BENEFITS PROVIDED (Continued)

Vision Care Benefits Levels I-III. The Plan has contracted with Union Eyes, Inc., EyeMed (formerly Cole Vision) and others, to provide a fully paid eye care program for all covered participants and their spouses and dependent children. Vision Care Benefit Level I provides for an eye examination and a standard pair of glasses, bifocal or trifocal lenses, once every 24 months for adults and one every 12 months for children under the age of 19. Level I coverage also provides an allowance for contact lenses.

Vision Care Benefit Levels II and III provide similar benefits for eligible participants and their spouses and dependent children. Levels II and III provide adult coverage every 12 months whereas Level I provides coverage every 24 months. Vision Care Benefit Level III includes additional benefits for glasses such as basic tints, scratch coating, polycarbonate lenses, etc. The eye care programs are self-funded.

NOTE E -- BENEFIT OBLIGATIONS

The Plan has adopted the American Institute of Certified Public Accountants' Statement of Position (SOP 92-6), "Accounting and Reporting by Health and Welfare Benefit Plans", as amended. The statement requires plans to account for and separately report benefit obligations, including post-retirement benefit obligations, if any.

The Plan has a continuing obligation for claims incurred by active participants that have not been reported as of the last day of the Plan year. An aggregate estimated amount of claims incurred but not reported, based on a statistical lag analysis review of claims paid subsequent to the year-end for certain time periods, has been determined. Accordingly, at February 28, 2025 and February 29, 2024, the Plan had provided \$1,650,000 and \$1,300,000, respectively, for such unreported claims.

The total and permanently disabled life insurance reserve (TPD Reserve) is a reserve for the payment of future life insurance claims of disabled participants who have extended life insurance benefits. MedMutual Life Insurance Company provides this coverage after 12/31/15. The agreement with MedMutual Life Insurance Company does not require a separate escrow reserve account, however the Plan maintains a calculated reserve of 25% of the amount of insurance in force on the lives of disabled participants. For the years ended February 28, 2025 and February 29, 2024, this reserve is \$38,800 and \$36,800 respectively.

The Plan has adopted a policy of providing hospitalization and medical insurance benefits for its four administrative, and four former supervisors and bookkeeping, non-bargaining unit retirees and spouses. A calculation of the estimated actuarial cost of this benefit obligation was made in a prior year, by a firm of consulting actuaries, and a determination was made that the amount is immaterial. Accordingly, no post-retirement benefit obligation has been recorded by the Plan for this benefit. There are no other post-retirement benefits.

NOTE F -- PRIORITIES UPON TERMINATION

It is the intent of the Trustees of the Plan to continue the Plan in full force and effect. However, in the event of termination of the Trust, the Trustees shall apply the assets of the Plan to provide for the payment of all obligations of the Plan and shall distribute any remaining surplus in accordance with the provisions of ERISA and the provisions of the Plan. Furthermore, the corpus or the income of the Plan may be used only for the exclusive benefit of the participants and their eligible dependents, or the payment of administrative expenses of the Plan, and shall not revert or accrue to the benefit of any employer or union.

NOTE G -- PROPERTY AND EQUIPMENT

At February 28, 2025 and February 29, 2024, the balances of the major classes of property and equipment and the related accumulated depreciation are as follows:

	February 28, 2025		February 29, 2024	
	Cost	Accumulated Depreciation	Cost	Accumulated Depreciation
Office furniture and equipment	\$ 177,441	\$ 174,080	\$ 177,443	\$ 169,061
Computer equipment	119,145	97,504	110,534	92,201
Computer software	115,706	115,706	115,706	115,706
Leasehold improvements	47,360	46,945	47,360	46,527
	<u>\$ 459,652</u>	<u>\$ 434,235</u>	<u>\$ 451,043</u>	<u>\$ 426,557</u>

Depreciation and amortization expense was \$7,679 and \$6,116 for the years ended February 28, 2025 and February 29, 2024, respectively.

NOTE H -- LEASE COMMITMENTS

The Plan leases office space at 1603 East 27th Street, Cleveland, Ohio, at 213 Tennessee Avenue, Cincinnati, Ohio, on a month-to-month basis. All of the leases are with Ohio Council 8 of AFSCME, a related-party and owner of the properties. The monthly rental rates are \$2,312 for Cleveland, and \$1,425 for Cincinnati. Additionally, there was a lease for an office in Toledo, Ohio (which was closed in May, 2024) during the year which expired and rent was paid at \$115 monthly through November, 2024.

NOTE I -- PARTY-IN-INTEREST TRANSACTIONS

The Plan has invested in shares of money market funds managed by Merrill Lynch, Morgan Stanley, and Keybank. Merrill Lynch, Morgan Stanley, and Keybank is therefore the Plan's custodian and is a fiduciary as defined by the Plan; therefore, these transactions qualify as party-in-interest. Fees paid by the Plan for these services was \$27,158 and \$22,815 for the years ended February 28, 2025 and February 29, 2024, respectively.

NOTE J -- DEPOSITS IN EXCESS OF FEDERALLY INSURED LIMITS

The Plan has multiple certificates of deposit and money market accounts at various financial institutions. The Federal Deposit Insurance Corporation (FDIC) insures deposits, including accrued interest through the date of the insured bank's closing, up to \$250,000 per depositor per insured bank. This threshold is permanent as of July 2013. Normally, the Plan diversifies its investments so as not to exceed this limit.

Note L-- Reclassification

Certain amounts from the prior year have been reclassified to conform with current year presentation

OHIO AFSCME CARE PLAN
 EIN #34-1133688 Plan No. 501

Schedule H, Line 4(i) - Schedule of Assets Held at the End of the Year
 February 28, 2025

(b) Identity of issue	(c) Description of investment	(d) Cost	(e) Current Value
Common stocks			
ANSYS Inc	15 Shares	5,192	4,999
ABBOTT LABS	124 Shares	13,419	17,113
ABBVIE INC	47 Shares	7,702	9,824
ACCENTURE PLC	32 Shares	3,502	11,152
ADOBE INC	18 Shares	9,304	7,894
AGILENT TECH INC	46 Shares	5,532	5,884
AKAMAI TECH	45 Shares	4,163	3,631
ALBANY INTL CRP	33 Shares	3,033	2,527
ABLEMARLE CORP	33 Shares	6,781	2,542
ALPHABET INC SHS	496 Shares	62,153	85,421
AMER EXPRESS	47 Shares	7,606	14,145
AMERICAN WTR WKS	48 Shares	7,019	6,527
APPLE INC	513 Shares	91,612	124,064
APPLIED MATERIAL INC	107 Shares	15,340	16,913
APTIV PLC	71 Shares	7,879	4,624
ARCHROCK INC	345 Shares	3,481	9,356
ARROW ELECTRONICS	37 Shares	5,299	3,999
AT&T INC	398 Shares	5,777	10,909
AUTODESK INC	33 Shares	7,060	9,049
AUTOMATIC DATA PROC	25 Shares	5,729	7,880
BEST BUY	71 Shares	5,701	6,384
BIO RAD LABS	16 Shares	5,884	4,243
BIOGEN INC	35 Shares	7,629	4,918
BLACKROCK INC	18 Shares	13,142	17,600
BORG WARNER	119 Shares	5,252	3,543
BOSTON SCIENTIFIC	183 Shares	10,712	18,994
BOX INC	172 Shares	5,109	5,624
BRISTOL-MYERS SQUIBB	163 Shares	10,127	9,718
BROADCOM INC	186 Shares	42,094	37,094
BXP INC	66 Shares	4,183	4,681
CABOT CORP	50 Shares	3,416	4,300
CAPITAL ONE FINL	90 Shares	10,044	18,050
CARRIER GLOBAL CORP	75 Shares	3,997	4,860
CATERPILLAR INC	42 Shares	11,128	14,446
CBRE GRP INC	121 Shares	10,575	17,175
CENCORA INC	34 Shares	6,524	8,620
CENTENE CORP	150 Shares	10,093	8,724
CF INDS HLDGS	79 Shares	5,844	6,401
CHARLES RIVER LABS	28 Shares	5,896	4,629
CHEVRON CORP	94 Shares	13,746	14,910
CIRRUS LOGIC INC	47 Shares	3,729	4,898
CISCO SYSTEMS INC	232 Shares	11,663	14,874
CITIGROUP INC COM NEW	272 Shares	12,515	21,746
COLGATE PALMOLIVE	83 Shares	7,348	7,567
COMCAST CORP NEW	389 Shares	15,948	13,957
CONMED CORP	54 Shares	6,138	3,195
COPT DEFENSE PROP	111 Shares	2,814	3,000
COSTCO WHOLESALE	25 Shares	9,655	26,215
CUMMINS INC	21 Shares	5,299	7,732
D R HORTON INC	30 Shares	3,881	3,804
DANAHER CORP	29 Shares	6,180	6,025
DARDEN RESTAURANTS	27 Shares	4,506	5,412
DECKERS OUTDOORS CORP	24 Shares	4,964	3,345
DEERE CO	23 Shares	9,518	11,058

OHIO AFSCME CARE PLAN

EIN #34-1133688 Plan No. 501

Schedule H, Line 4(i) - Schedule of Assets Held at the End of the Year
February 28, 2025

(b) Identity of issue	(c) Description of investment	(d) Cost	(e) Current Value
EASTMAN CHEMICAL	48 Shares	4,164	4,697
EATON CORP	42 Shares	8,526	12,319
EBAY INC	264 Shares	12,249	17,091
ECOLAB	41 Shares	7,719	11,029
ELECTRONIC ARTS	42 Shares	5,767	5,423
ELEVANCE HEALTH	25 Shares	11,902	9,922
EMERSON ELEC	44 Shares	3,759	5,351
EQUINIX	12 Shares	9,638	10,855
FIDELITY NATL INFO SVCS	132 Shares	7,723	9,388
FIRSTCASH HLDGS	34 Shares	3,227	3,818
FORMFACTOR INC	101 Shares	3,783	3,363
FORTIVE CORP	65 Shares	4,833	5,170
GATX CORP	50 Shares	6,440	8,353
GENERAL MILLS	149 Shares	11,170	9,032
GENERAL MOTORS	314 Shares	11,749	15,427
GILEAD SCIENCES INC	95 Shares	7,359	10,859
HERSHEY CO	37 Shares	8,834	6,390
HEWLETT PACKARD	274 Shares	4,694	5,428
HEXCEL CORP NEW	71 Shares	5,388	4,499
HOLOGIC INC	70 Shares	5,651	4,437
HOME DEPOT	54 Shares	17,045	21,416
HOULIHAN LOKEY	47 Shares	4,775	8,147
HUNTINGTON INGALLS INDS	25 Shares	5,503	4,390
HUNTINGTON BANCSHS INC	348 Shares	5,190	5,732
ILLINOIS TOOL WORKS	28 Shares	6,962	7,391
INSPERITY	46 Shares	5,202	4,047
INTUIT INC	18 Shares	8,735	11,049
IQVIA HLDGS	22 Shares	4,809	4,154
JOHNSON CONTROLS INTER	91 Shares	6,268	7,795
LAM RESEARCH	140 Shares	8,952	10,744
LINDE PLC	28 Shares	11,195	13,077
LOWES COMPANIES	34 Shares	7,827	8,454
MARATHON PETROLEUM CORP	39 Shares	6,514	5,857
MARRIOTT INTL INC	70 Shares	17,674	19,632
MARSH & MCLENNAN COS INC	37 Shares	7,756	8,800
MASTERCARD	42 Shares	16,914	24,205
MERCK AND CO	140 Shares	15,057	12,915
METLIFE	120 Shares	6,992	10,342
MICROSOFT	282 Shares	67,825	111,951
MIDDLEBY CORP	37 Shares	5,136	6,120
MONOLITHIC PWR SYSTEMS	8 Shares	4,565	4,888
MOODYS CORP	25 Shares	9,097	12,599
MOOG INC	40 Shares	4,425	6,820
MYRIAD GENETICS	154 Shares	3,460	1,652
NASDAQ OMX GRP INC	70 Shares	5,178	5,795
NEXTERA ENERGY	130 Shares	3,968	9,122
NIKE	112 Shares	12,090	8,896
NVIDIA	940 Shares	7,526	117,425
ON SEMICONDUCTOR	66 Shares	6,617	3,105
ORACLE CORP	91 Shares	15,416	15,111
OTIS WORLDWIDE CORP	46 Shares	4,077	4,590
PAPA JOHNS	93 Shares	6,234	4,218
PAYPAL HOLDINGS	111 Shares	8,031	7,887
PENN ENTERTAINMENT	99 Shares	2,439	2,129
PPG INDUSTRIES INC	38 Shares	5,387	4,302

OHIO AFSCME CARE PLAN

EIN #34-1133688 Plan No. 501

Schedule H, Line 4(i) - Schedule of Assets Held at the End of the Year
February 28, 2025

(b) Identity of issue	(c) Description of investment	(d) Cost	(e) Current Value
PROCTOR & GAMBLE	139 Shares	22,605	24,164
PROGRESSIVE CRP	59 Shares	6,888	16,638
PROLOGIS INC	108 Shares	13,426	13,383
PUB SVC ENTERPRISE	133 Shares	8,402	10,793
QIAGEN NV REG	104 Shares	4,868	3,994
QUALCOMM INC	73 Shares	8,909	11,473
QUANTNA SERVICES INC	34 Shares	9,379	8,827
RAYMOND JAMES FINL	47 Shares	4,949	7,269
REINSURANCE GROUP AMERICA	36 Shares	5,071	7,297
REPUBLIC SERVICES	26 Shares	3,898	6,163
RYDER SYSTEM	46 Shares	4,063	7,566
S&P GLOBAL	28 Shares	11,664	14,945
SALESFORCE	76 Shares	15,046	22,637
SBA COMMUNICATIONS	23 Shares	5,529	5,012
SCHLUMBERGER LTD	281 Shares	15,968	11,706
SEMPRA	169 Shares	12,651	12,095
SERVICENOW	19 Shares	11,929	17,665
SMITH A O CORP DEL	76 Shares	5,643	5,052
SNAP ON INC	19 Shares	5,553	6,482
SONOCO PRODUCTS	77 Shares	4,440	3,682
STERIS PLC REG	20 Shares	4,550	4,385
T-MOBILE US INC	57 Shares	11,320	15,372
TARGET	55 Shares	7,202	6,833
TELEDYNE TECH	15 Shares	6,189	7,725
THERMO FISHER SCIENTIFIC	22 Shares	11,554	11,637
TJX COS	128 Shares	10,853	15,969
TRACTOR SUPPLY	175 Shares	7,561	9,686
TRANE TECHNOLOGIES	17 Shares	6,481	6,013
ULTA BEAUTY	20 Shares	8,808	7,327
UNITEDHEALTH GROUP	40 Shares	9,680	18,998
US BANCORP	287 Shares	10,187	13,460
VALERO ENERGY	97 Shares	7,480	12,681
VALMONT INDUSTRIES	16 Shares	4,354	5,574
VERALTO	48 Shares	4,895	4,788
VERTEX PHARMCTLS	23 Shares	7,621	11,035
VISA INC	95 Shares	21,896	34,457
W W GRAINGER	12 Shares	9,153	12,255
WABTEC	29 Shares	4,634	5,375
WALMART	184 Shares	14,456	18,144
WEBSTER FINL CP	85 Shares	3,584	4,787
WEC ENERGY GROUP	47 Shares	4,173	5,014
WELLS FARGO & CO	197 Shares	11,203	15,429
WELLTOWER INC	55 Shares	5,554	8,443
WEX INC	26 Shares	5,406	4,085
WEYWEHAEUSER	175 Shares	5,479	5,268
WILLAIMS SONOMA INC	26 Shares	4,716	5,059
WINTRUST FINL	37 Shares	5,092	4,605
WOODWARD INC	38 Shares	4,533	7,182
XYLEM INC	46 Shares	5,039	6,021
ZOETIS	51 Shares	8,808	8,529
Common Stocks	14,949 Shares	1,465,592	1,896,777

OHIO AFSCME CARE PLAN
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Schedule H, Line 4(i) - Schedule of Assets Held at the End of the Year
February 28, 2025

(b) Identity of issue	(c) Description of investment	(d) Cost	(e) Current Value
<u>Mutual Funds</u>			
Vanguard FTSE Developed	8095 Shrs	413,412	413,412
Vanguard Russell 1000 ET	6914 Shrs	590,110	590,110
Vanguard Short Term Corp Bond	60247.06 Shrs	1,289,890	1,289,890
		<hr/>	<hr/>
Mutual Funds	67161.06 Shrs	1,880,000	2,293,412
Total Common Stocks & Mutual funds		<hr/> <hr/>	<hr/> <hr/>
<u>Money Market Accounts</u>			
Key Bank		1,802,634	1,802,634
Merrill Lynch		829,333	829,333
Morgan Stanley		304,932	304,932
Total Money Market		<hr/> <hr/>	<hr/> <hr/>
<u>Annuity Contracts</u>			
F & G Annuities and Life		267,051	275,997
		<hr/>	<hr/>
<u>Keybank Holdings</u>			
Fifth Third Bank	2.25% 2/7/1955	92,947	96,070
Citigroup Inc Fxd Rt	5.50% 9/13/2025	102,084	100,384
Morgan Stanley	3.95% 4/23/2027	391,320	395,040
Morgan Stanley Fxd Rt	3.88% 1/27/2026	102,046	99,454
JP Morgan Chase	3.90% 7/15/2025	484,150	498,750
Keybank Natl Assn	3.40% 5/20/2026	509,555	492,155
		<hr/>	<hr/>
		1,682,103	1,681,853
<u>Held By Merrill Lynch</u>			
United States Treasury Note	4.63% 6/30/2025	245,000	245,262
United States Treasury Note	3.88% 1/15/2026	1,090,000	1,087,526
United States Treasury Note	4.13% 2/15/2027	288,000	288,674
United States Treasury Note	4.25% 3/15/2027	243,000	244,205
United States Treasury Note	4.25% 3/15/2027	61,000	61,302
United States Treasury Note	4.63% 6/15/2027	244,000	247,431
United States Treasury Note	4.63% 6/15/2027	60,000	60,844
United States Treasury Note	4.13% 9/30/2027	244,000	244,954
United States Treasury Note	4.00% 9/30/2027	60,000	60,234
United States Treasury Note	Zero Cup 11/15/2027	363,000	325,266
United States Treasury Note	3.88% 12/31/2027	248,000	247,380
United States Treasury Note	3.88% 12/31/2027	61,000	60,847
United States Treasury Note	4.38% 11/30/2028	520,000	526,724
Credit Suisse	1.25% 8/7/2026	250,000	239,313
Truist Financial Corp	1.13% 8/3/2027	250,000	230,928
Goldman Sachs	1.50% 9/15/2027	250,000	229,330
Keybank Natl Assn	3.40% 5/20/2026	250,000	246,100
HSBC Hldgs PLC	3.90% 5/25/2026	250,000	248,510
Discover Bk	3.45% 7/27/2026	250,000	245,675
Morgan Stanley	3.95% 4/23/2027	250,000	246,943
PNC Finl Svcs	3.15% 5/19/2027	250,000	243,015
		<hr/>	<hr/>
		5,727,000	5,630,463
Total of other interest bearing investments.		<hr/> <hr/>	<hr/> <hr/>
		7,409,103	7,588,313

OHIO AFSCME CARE PLAN

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Schedule H, Line 4(i) - Schedule of Assets Held at the End of the Year
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(b) Identity of issue	(c) Description of investment	(d) Cost	(e) Current Value
<u>Certificates of Deposits</u>			
Held By AFSCME			
Pioneer Savings Bank	1.750% 6/15/2026	250,000	250,000
		<u>250,000</u>	<u>250,000</u>
Held By Morgan Stanley			
American Express Sandy UT	2.900% 5/5/2025	250,000	249,335
American Natl Bk Appleton WI	3.800% 4/30/2027	250,000	247,703
First Gty Bk Hamm	4.150% 3/6/2026	200,000	199,740
Goldman Sachs New York	3.000% 5/12/2025	250,000	249,315
BMO BK Chicago IL	4.750% 12/15/2025	250,000	250,930
United Bankers Bk Bloomington	3.900% 9/11/2026	200,000	198,980
UBS Bk USA Salt Lake City	3.950% 10/30/2026	250,000	248,768
Plains St Bk Humble TX	3.950% 1/25/2027	230,000	228,783
Wells Fargo Bk N Sioux Falls SD	4.900% 12/19/2025	250,000	251,293
BK of America Charlotte NC	4.400% 2/29/2026	250,000	250,375
Golden Bank Houston TX	4.400% 2/13/2026	250,000	250,383
Hanmi Bank Los Angeles CA	3.900% 7/16/2027	200,000	198,412
Valley Natl Bk Passaic NJ	3.850% 10/29/2027	250,000	247,388
Flagstar BK Natl Hicksville NY	4.750% 2/27/2026	250,000	251,285
Bank Buffalo KY	3.750% 10/29/2027	31,000	30,598
		<u>3,361,000</u>	<u>3,353,286</u>
<u>Held By Merrill Lynch</u>			
Amerant Bank	3.850% 9/20/2027	245,000	242,148
Pacific Western BK Beverly Hill CA	0.700% 5/29/2025	250,000	247,748
Lincoln 1st Bank	0.500% 8/19/2025	250,000	245,543
USAA Federal Savings	5.300% 9/26/2025	243,000	244,713
Citibank	5.300% 9/29/2025	243,000	244,300
UBS Bank USA	5.100% 10/5/2026	248,000	251,291
Synchrony Bank	5.050% 10/6/2026	243,000	245,873
Morton Cmnty BK	0.600% 6/19/2025	250,000	247,310
Continental BK Salt Lke City	0.550% 6/26/2025	250,000	246,933
Jonesboro State Bank	0.500% 8/7/2025	250,000	245,876
Bank Hapoalim	0.450% 9/15/2025	250,000	244,865
Somerset Tr Co	1.050% 9/19/2025	244,525	245,540
Bridgewater BK	0.400% 10/7/2025	250,000	244,188
Haddon Savings BK	0.350% 10/20/2025	250,000	243,805
Old Dominion Natl BK	0.400% 10/30/2025	250,000	243,603
JPMorgan Chase Bk	0.550% 12/31/2025	250,000	242,388
Poppy BK	1.150% 3/18/2026	245,775	242,023
First Natl BK Amer	1.050% 3/27/2026	246,003	241,575
Western St BK	1.150% 5/13/2026	250,000	240,928
Encore BK	0.750% 5/29/2026	250,000	239,323
Enterprise BK	0.850% 6/5/2026	250,000	239,525
Metropolitan Cap Bk	0.550% 11/18/2026	250,000	234,753
Hiawatha Natl Bank	0.400% 11/25/2025	249,818	242,990
Texas Exchange Bank	0.600% 11/25/2025	250,000	243,068
Central Bank	0.400% 11/28/2025	250,000	242,915
Unity Bank	0.400% 12/18/2025	250,000	242,398
Security St Bk/Farwel	0.500% 12/23/2025	250,000	242,468
Landmark Cmnty Bank	0.450% 12/30/2025	250,000	242,183
Truxton Trust Co	0.400% 2/2/2026	249,193	241,268
State Bk India Chicago IL	0.500% 2/25/2026	247,085	240,915
Exchange BK	0.550% 5/19/2026	250,000	238,990

OHIO AFSCME CARE PLAN

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<u>(b) Identity of issue</u>	<u>(c) Description of investment</u>	<u>(d) Cost</u>	<u>(e) Current Value</u>
		<u>7,704,399</u>	<u>7,541,443</u>
Total Certificates of Deposit		<u>7,954,399</u>	<u>11,144,728</u>
Total Investments		<u>25,006,992</u>	<u>25,860,129</u>

34-6726788

Federal Statements
Ohio AFSCME Care Plan
Plan: 501

Assets Held for Investment

<u>Party in Interest</u>	<u>Identity</u>	<u>Description</u>	<u>Cost</u>	<u>Current Value</u>
	SEE ATTACHED AUDITED	F/S	\$	\$