

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025

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

Part II Basic Plan Information—enter all requested information

1a Name of plan: FOX VALLEY LABORERS HEALTH & WELFARE FUND
1b Three-digit plan number (PN): 501
1c Effective date of plan: 10/01/1968
2a Plan sponsor's name (employer, if for a single-employer plan): TRUSTEES OF FOX VALLEY LABORERS HEALTH AND WELFARE FUND
2b Employer Identification Number (EIN): 36-6219639
2c Plan Sponsor's telephone number: 847-742-0900
2d Business code (see instructions): 237310

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

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

Table with 4 columns: SIGN HERE, Signature, Date, Name. Rows for plan administrator (BRIAN URSO), employer/plan sponsor (BRIAN RAUSCH), and DFE.

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

Form 5500 (2024) v. 240311

| | | |
|---|--|------|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 2075 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6a(1) | 1513 |
| | 6a(2) | 1418 |
| | 6b | 583 |
| | 6c | |
| | 6d | 2001 |
| | 6e | |
| | 6f | |
| | 6g(1) | |
| 6g(2) | | |
| 6h | | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | 184 |

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

For calendar plan year 2024 or fiscal plan year beginning **06/01/2024** and ending **05/31/2025**

| | | |
|---|--|-------------------|
| <p>A Name of plan FOX VALLEY LABORERS HEALTH & WELFARE FUND</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 TRUSTEES OF FOX VALLEY LABORERS HEALTH AND WELFARE FUND</p> | <p>D Employer Identification Number (EIN) 36-6219639</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
THE UNION LABOR LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 13-1423090 | 69744 | SL10475 | 1825 | 06/01/2024 | 05/31/2025 |

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</p> <p style="text-align: center;">0</p> | <p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p> |
|---|--|

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

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

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

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

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

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

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

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

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

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| | (c) Amount | (d) Purpose | |
| | | | |

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|--------|
| a | Total premiums or subscription charges paid to carrier | 10a | 293198 |
| 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. |
|--|--|---|

For calendar plan year 2024 or fiscal plan year beginning **06/01/2024** and ending **05/31/2025**

| | | |
|---|--|------------|
| A Name of plan FOX VALLEY LABORERS HEALTH & WELFARE FUND | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF FOX VALLEY LABORERS HEALTH AND WELFARE FUND | D Employer Identification Number (EIN) 36-6219639 | |

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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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)

HEALTH CARE SERVICES CORP(BC/BS)

36-1236610

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 | NONE | 1012523 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

SEI INVESTMENTS

23-1707341

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 28 51 52 | NONE | 325334 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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

HINES & ASSOCIATES, INC.

36-3545085

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 16 | NONE | 243857 | 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)

HORIZON ACTUARIAL SERVICES, LLC

26-1370698

| (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? |
|------------------------|---|--|--|--|---|--|
| 11 16 | NONE | 237433 | 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)

PALMER, TANYA

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 154274 | 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)

CVS HEALTH

05-0340626

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 | NONE | 146361 | 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)

JOANNA LOPEZ

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 141399 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 16 | NONE | 128356 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

DEBORAH FRENCH

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 125608 | 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)

ELINA LLAMAS

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 125484 | 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)

DIAZ, MARIA

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 102538 | 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)

DAISY ALVARADO

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 91431 | 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)

BAUM SIGMAN AUERBACH & NEUMAN, LTD.

36-2744057

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29 | NONE | 87369 | 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)

NORTHERN TRUST CO

36-1561860

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 19 | NONE | 82257 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

CALIBRE CPA GROUP, PLLC

47-0900880

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 | NONE | 80157 | 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)

DAVID UGARTE

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 65367 | 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)

CIMINO, MICHELE A

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 64344 | 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)

ALEJANDRES, ALEXANDRIA

36-6219639

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 30 | EMPLOYEE | 55268 | 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)

DENTAL NETWORK OF AMERICA

36-3339483

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 | NONE | 48498 | 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)

ALLONE HEALTH RESOURCES INC.

36-3867645

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 49 | NONE | 36644 | 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)

ALLEGRA COAL CITY

32-0447805

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 36 | NONE | 26682 | 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)

NORTHERN PRINT NETWORK

36-3363479

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 36 | NONE | 18740 | 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)

GREEN LIGHT COST MANAGEMENT, LLC

45-5248276

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 49 | NONE | 18682 | 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)

IKON SOFTWARE INC.

36-4329379

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 16 | NONE | 15123 | 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)

EYEMED VISION CARE, INC.

31-1656473

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 | NONE | 12614 | 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)

BMI AUDIT SERVICES, LLC

38-4091484

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 49 | NONE | 10410 | 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)

AUTOMATIC DATA PROCESSING, INC.

408 S. SHELBY ST.
HOBART, IN 46342

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 15 | NONE | 7606 | 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)

BASSLER & CO INSURANCE AGENCY

611 ACADEMY DR
NORTHBROOK, IL 60062

| (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? |
|------------------------|---|--|--|--|---|--|
| 53 | NONE | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | 5237 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

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

(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 |
|---|--------------------------------------|---|
| BASSLER & CO INSURANCE AGENCY | 53 | 5237 |

| (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. | |
|--|--|--|
| HUDSON INSURANCE CO 101 N WACKER DRIVE, STE 1950 CHICAGO, IL 60606 | COMMISSION FOR PROCUREMENT OF FIDUCIARY LIABILITY INSURANCE. | |

| (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. | OMB No. 1210-0110 2024 This Form is Open to Public Inspection |
|--|--|---|

| | |
|---|--|
| For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025 | |
| A Name of plan FOX VALLEY LABORERS HEALTH & WELFARE FUND | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF FOX VALLEY LABORERS HEALTH AND WELFARE FUND | D Employer Identification Number (EIN) 36-6219639 |

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

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

| Assets | (a) Beginning of Year | (b) End of Year |
|--|------------------------------|------------------------|
| a Total noninterest-bearing cash | 1a | |
| b Receivables (less allowance for doubtful accounts): | | |
| (1) Employer contributions | 1b(1) | 4660773 |
| (2) Participant contributions | 1b(2) | |
| (3) Other | 1b(3) | 257548 |
| c General investments: | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 746912 |
| (2) U.S. Government securities | 1c(2) | |
| (3) Corporate debt instruments (other than employer securities): | | |
| (A) Preferred | 1c(3)(A) | |
| (B) All other | 1c(3)(B) | |
| (4) Corporate stocks (other than employer securities): | | |
| (A) Preferred | 1c(4)(A) | |
| (B) Common | 1c(4)(B) | |
| (5) Partnership/joint venture interests | 1c(5) | |
| (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) | 124550867 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | |
| (15) Other | 1c(15) | 125368605 |

| 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 | 71645 | 70098 |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 130287745 | 134975425 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | 1692068 | 1488746 |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 25996674 | 29943851 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 27688742 | 31432597 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 102599003 | 103542828 |

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) | 39272889 | |
| (B) Participants..... | 2a(1)(B) | 2018511 | |
| (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) | | 41291400 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 80907 | |
| (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) | | 80907 |
| (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) | 5064406 | |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C)..... | 2b(2)(D) | | 5064406 |
| (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) | | |
| (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) | | 5399749 |
| c Other income | 2c | | 132911 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 51969373 |

Expenses

| | | | |
|---|---------------|----------|----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 47095424 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | 293198 | |
| (3) Other | 2e(3) | 1191760 | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 48580382 |
| 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) | 995750 | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Recordkeeping fees | 2i(3) | 55792 | |
| (4) IQPA audit fees | 2i(4) | 24365 | |
| (5) Investment advisory and investment management fees | 2i(5) | 471750 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | 82257 | |
| (7) Actuarial fees | 2i(7) | 237433 | |
| (8) Legal fees | 2i(8) | 87369 | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | 18113 | |
| (11) Other expenses | 2i(11) | 472337 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 2445166 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 51025548 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|--------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 943825 |
| 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: CALIBRE CPA GROUP, PLLC

(2) EIN: 47-0900880

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. | | X | |

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 _____.



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

FINANCIAL STATEMENTS

MAY 31, 2025





**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

FINANCIAL STATEMENTS
WITH SUPPLEMENTAL INFORMATION

YEARS ENDED MAY 31, 2025 AND 2024

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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Fox Valley Laborers
Health and Welfare Fund
Elgin, Illinois

Opinion

We have audited the accompanying financial statements of the Fox Valley Laborers Health and Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of May 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Fox Valley Laborers Health and Welfare Fund as of May 31, 2025 and 2024, and the changes in its net assets available for benefits and its benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.


Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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





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


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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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



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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Other Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Calibre CPA Group, PLLC

Chicago, IL
January 15, 2026



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

MAY 31, 2025 AND 2024

| | 2025 | 2024 |
|--|-----------------------|-----------------------|
| Assets | | |
| Investments, at fair value | <u>\$ 129,008,264</u> | <u>\$ 125,297,779</u> |
| Receivables | | |
| Employer contributions | 5,556,967 | 4,660,773 |
| Investment income | 241,915 | 247,503 |
| Stop-loss claim and dividend receivables | <u>98,181</u> | <u>10,045</u> |
| Total receivables | <u>5,897,063</u> | <u>4,918,321</u> |
| Prepaid expenses | <u>54,692</u> | <u>54,148</u> |
| Furniture and equipment | 388,902 | 384,615 |
| Less: accumulated depreciation | <u>(373,496)</u> | <u>(367,118)</u> |
| Net furniture and equipment | <u>15,406</u> | <u>17,497</u> |
| Total assets | <u>134,975,425</u> | <u>130,287,745</u> |
| Liabilities | | |
| Cash overdraft | 157,395 | 68,771 |
| Accounts payable and accrued expenses | 106,426 | 109,280 |
| Reciprocity payable | 1,382,320 | 1,582,788 |
| Due to affiliated funds | 73,035 | 37,482 |
| Deposits held | <u>112,421</u> | <u>117,421</u> |
| Total liabilities | <u>1,831,597</u> | <u>1,915,742</u> |
| Net assets available for benefits | <u>\$ 133,143,828</u> | <u>\$ 128,372,003</u> |

See accompanying notes to financial statements.



FOX VALLEY LABORERS HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED MAY 31, 2025 AND 2024

| | 2025 | 2024 |
|--|----------------|----------------|
| Additions | | |
| Contributions | | |
| Employer | \$ 28,437,630 | \$ 26,007,886 |
| Reciprocity received | 17,274,188 | 16,659,571 |
| Reciprocity paid | (6,438,929) | (5,656,728) |
| COBRA and retiree | 2,018,511 | 1,894,944 |
| Net contributions | 41,291,400 | 38,905,673 |
| Investment income | | |
| Appreciation in fair value of investments | 5,399,749 | 7,437,897 |
| Interest and dividends | 5,278,224 | 4,727,653 |
| Investment management expenses | (554,007) | (544,620) |
| Net investment income | 10,123,966 | 11,620,930 |
| Total additions | 51,415,366 | 50,526,603 |
| Deductions | | |
| Cost of benefits | | |
| Claims paid | | |
| Medical, dental, vision and death | 34,389,987 | 30,071,544 |
| Prescription drug expense | 8,568,727 | 7,336,283 |
| Disability payments | 308,710 | 280,959 |
| Total claims paid (net) | 43,267,424 | 37,688,786 |
| Medicare D subsidies received | (275,771) | (239,430) |
| Stop-loss claim reimbursement | (87,919) | - |
| Medical consulting fees | 219,911 | 266,597 |
| Member assistance program | 36,644 | 35,805 |
| Payroll taxes on disability payments | 43,718 | 39,127 |
| PPO access and claim negotiation fee | 1,133,428 | 921,938 |
| Prescription administrative fees and costs | 146,361 | 125,518 |
| Stop-loss insurance premiums | 268,586 | 264,224 |
| Total cost of benefits | 44,752,382 | 39,102,565 |
| Fees mandated by the Patient Protection and Affordable Care Act | 11,826 | 10,772 |
| General and administrative expenses | 1,879,333 | 1,809,742 |
| Total deductions | 46,643,541 | 40,923,079 |
| Net change | 4,771,825 | 9,603,524 |
| Net assets available for benefits | | |
| Beginning of year | 128,372,003 | 118,768,479 |
| End of year | \$ 133,143,828 | \$ 128,372,003 |

See accompanying notes to financial statements.



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

STATEMENTS OF BENEFIT OBLIGATIONS

MAY 31, 2025 AND 2024

| | 2025 | 2024 |
|--|-----------------------|-----------------------|
| Amounts currently payable to or for participants, beneficiaries and dependents | | |
| Claims payable and claims incurred but not reported | \$ 7,128,000 | \$ 5,127,000 |
| Obligations for current benefit coverage, at present value of estimated amounts | | |
| Extended eligibility | 22,473,000 | 20,646,000 |
| Total benefits other than postretirement benefit obligations | 29,601,000 | 25,773,000 |
| Postretirement benefit obligations, net of amounts currently payable | | |
| Retirees | 191,361,306 | 159,684,185 |
| Actives fully eligible | 126,530,886 | 183,256,946 |
| Actives not fully eligible | 121,455,675 | 75,258,362 |
| Total postretirement benefit obligations | 439,347,867 | 418,199,493 |
| Total benefit obligations | <u>\$ 468,948,867</u> | <u>\$ 443,972,493</u> |

See accompanying notes to financial statements.



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED MAY 31, 2025 AND 2024

| | 2025 | 2024 |
|--|----------------|----------------|
| Amounts currently payable to or for participants, beneficiaries and dependents | | |
| Balance at beginning of year | \$ 5,127,000 | \$ 3,870,000 |
| Claims incurred | 45,268,424 | 38,945,786 |
| Claims paid | (43,267,424) | (37,688,786) |
| Balance at end of year | 7,128,000 | 5,127,000 |
| Other obligations for current benefit coverage, at present value of estimated amounts | | |
| Balance at beginning of year | 20,646,000 | 19,867,000 |
| Change during year | | |
| Extended eligibility | 1,827,000 | 779,000 |
| Balance at end of year | 22,473,000 | 20,646,000 |
| Total obligations other than postretirement benefit obligations at end of year | 29,601,000 | 25,773,000 |
| Postretirement benefit obligations, net of amounts currently payable | | |
| Balance at beginning of year | 418,199,493 | 435,536,682 |
| Changes during year attributed to | | |
| Benefits earned | 6,945,026 | 8,090,376 |
| Interest on obligation | 23,021,923 | 21,874,234 |
| Expected benefit payments during the year | (13,128,208) | (12,284,757) |
| Changes in data and assumptions | 4,309,633 | (35,017,042) |
| Total postretirement benefit obligations at end of year | 439,347,867 | 418,199,493 |
| Total benefit obligations at end of year | \$ 468,948,867 | \$ 443,972,493 |

See accompanying notes to financial statements.



FOX VALLEY LABORERS HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED MAY 31, 2025 AND 2024

NOTE 1. DESCRIPTION OF THE PLAN

The following description of the Fox Valley Laborers Health and Welfare Fund (the Plan) provides only general information. Participants should refer to the Plan Document for a more complete description of the Plan's provisions.

General - The Plan is a self-funded plan which provides health and death benefits covering substantially all participating persons under the collective bargaining agreement between the Laborers International Union of North America, Local Unions No. 582 and No. 1035, AFL-CIO and the Chicagoland Associated General Contractors and the Illinois Road Builders Association. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The disbursements of the Plan are under the joint control of union designated and employer designated trustees.

Benefits - The Plan provides health (hospital, surgical, major medical, dental, vision, and disability) and death benefits covering employees who work the qualifying period as described in the Plan and for whom contributions have been made by contributing employers.

Contributions - The Board of Trustees (Trustees) established a funding policy and method in order to promote the purpose of the Trust Fund and to ensure compliance with ERISA. Each employer contributes to the Plan such amounts and at such times as are required by the applicable provisions of the collective bargaining agreement or such other agreements as are approved by the Trustees to provide benefits for employees. The revenue of the Plan is dependent on the continued activity of the employers of the Plan. Contributions are based on an hourly rate and are made on a monthly basis throughout the year. The hourly contribution rate through May 31, 2024 was \$15.28. Effective June 1, 2024, the hourly contribution rate increased to \$15.53. Self-contributions may be made by previously qualified employees under the conditions described in the Plan. The costs of the postretirement benefit obligations are shared by the participating employers and retirees. As of the May 31, 2025 and 2024, retirees are projected to contribute 12.2% and 12.6%, respectively, of the estimated cost of providing their postretirement benefits.

Other - The Plan's Trustees, as sponsor, have the right under the Plan to modify the benefits provided to active employees. The Plan may be terminated only by joint agreement between industry and union, subject to the provisions set forth in ERISA.



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting - The accompanying financial statements are prepared on the accrual basis of accounting. Under this basis, revenue is recognized when earned and expenses are recognized when 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, liabilities, benefit obligations and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Valuation of Investments and Income Recognition - Investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Purchases and sales of securities are recognized on a trade-date basis. Interest income is recognized on the accrual basis. Dividends are reported on the ex-dividend date. Appreciation in fair value of investments includes the Plan's gains and losses on investments bought and sold as well as held during the year. Cash and cash equivalents held by custodians for investment purposes are reported as investments.

Contributions Receivable - The Plan estimates amounts receivable from reporting employers at year-end based upon amounts collected subsequent to year-end. Employer records are subject to audit and additional revenue, if any, which may arise as a result of these audits, is recognized when received. Based on a review of historical losses, current economic conditions and supportable and reasonable forecast assumptions, management of the Plan has concluded that any expected credit losses on balances outstanding at year end will be immaterial.

Reciprocity - The Trustees have entered into reciprocity agreements with other welfare funds so that contributions will be transferred to an employee's home fund.

Stop-Loss - Claims that were already paid from the Plan that exceeded the stop-loss coverage and are due to the Plan at year-end are recorded as a receivable. Premiums for stop-loss insurance are included in the accompanying statements of changes in net assets available for benefits. Stop-loss insurance reimbursements are included in the accompanying statements of changes in net assets available for benefits.

Estimated Liability for Future Claims - The estimated liabilities for benefit claims incurred but unpaid and extended eligibility were prepared by the actuary to the Plan.

Furniture and Equipment - Furniture and equipment is stated at cost, less accumulated depreciation. Major additions are capitalized while maintenance and repairs, which do not improve or extend the lives of the respective assets, are expensed currently. Depreciation is computed over the estimated useful lives of 5 years for automobiles and 5 to 9 years for property and equipment by the straight-line method. Depreciation expense for the years ended May 31, 2025 and 2024 was \$6,377 and \$8,092, respectively.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Postretirement Benefit Obligations - The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing Plan assets.

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

The recognition of federal subsidies payable under the Medical Modernization Act of 2003 is determined by the actuary and is calculated by estimating a per capita amount applying prescription drug trends for retiree prescription drug plan federal subsidies that the Plan is eligible to receive. The Plan has been determined to be actuarially equivalent to the Medicare Part D Standard Benefit.

The following were significant assumptions used in the valuation as of May 31, 2025 and 2024, respectively:

| | 2025 | 2024 |
|-----------------------------|---|---|
| Discount rate | 5.75% | 5.50% |
| Mortality table | 125% of the PRI-2012 Mortality Tables (separate sex distinct tables for employees, retirees, and surviving spouses) with Blue Collar adjustment, projected generationally with 100% of Scale MP-2021. | 125% of the PRI-2012 Mortality Tables (separate sex distinct tables for employees, retirees, and surviving spouses) with Blue Collar adjustment, projected generationally with 100% of Scale MP-2021. |
| Cost trends | | |
| Medical | | |
| Current year trend | 8.00% | 8.00% |
| Ultimate year trend | 5.00% | 5.00% |
| Year of ultimate trend rate | 2031 | 2030 |
| Drug | | |
| Current year trend | 10.00% | 10.00% |
| Ultimate year trend | 6.00% | 6.00% |
| Year of ultimate trend rate | 2033 | 2032 |
| Dental and vision | | |
| Initial year trend rate | 3.50% | 3.50% |



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

NOTE 3. INVESTMENTS

As of May 31, 2025 and 2024, the Plan's investments are as follows:

| | <u>2025</u> | <u>2024</u> |
|---------------------------------|-----------------------|-----------------------|
| Registered investment companies | \$ 125,368,605 | \$ 124,550,867 |
| Cash equivalents | <u>3,639,659</u> | <u>746,912</u> |
| Total investments | <u>\$ 129,008,264</u> | <u>\$ 125,297,779</u> |

NOTE 4. FAIR VALUE MEASUREMENTS

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

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

Level 2 Inputs to the valuation methodology include other significant observable inputs including:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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



NOTE 4. FAIR VALUE MEASUREMENTS (CONTINUED)

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following are descriptions of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at May 31, 2025 and 2024.

Registered investment companies: Registered investment companies are valued using reported closing prices in the market in which the securities are traded.

Cash equivalents: Cash equivalents consist of shares of a short-term investment fund which is valued using amortized cost which approximates fair value.

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

Changes in Fair Value Levels

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

We evaluated the significance of transfers between levels based upon the nature of the financial instrument and size of the transfer relative to the total net assets available for benefits. For the years ended May 31, 2025 and 2024, there were no significant transfers in or out of Levels 1, 2 or 3.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of May 31, 2025:

| | Assets at Fair Value as of May 31, 2025 | | | |
|---------------------------------|---|-----------------------|-------------|-------------|
| | Total | Level 1 | Level 2 | Level 3 |
| Registered investment companies | \$ 125,368,605 | \$ 125,368,605 | \$ - | \$ - |
| Cash equivalents | <u>3,639,659</u> | <u>3,639,659</u> | <u>-</u> | <u>-</u> |
| | <u>\$ 129,008,264</u> | <u>\$ 129,008,264</u> | <u>\$ -</u> | <u>\$ -</u> |



NOTE 4. FAIR VALUE MEASUREMENTS (CONTINUED)

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of May 31, 2024:

| | Assets at Fair Value as of May 31, 2024 | | | |
|---------------------------------|---|-----------------------|-------------|-------------|
| | Total | Level 1 | Level 2 | Level 3 |
| Registered investment companies | \$ 124,550,867 | \$ 124,550,867 | \$ - | \$ - |
| Cash equivalents | <u>746,912</u> | <u>746,912</u> | <u>-</u> | <u>-</u> |
| | <u>\$ 125,297,779</u> | <u>\$ 125,297,779</u> | <u>\$ -</u> | <u>\$ -</u> |

NOTE 5. TAX STATUS

The Trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) as a tax-exempt organization. The Plan has obtained a favorable tax determination letter from the Internal Revenue Service, and the Plan sponsor believes that the Plan, as amended, continues to qualify and to operate in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the taxing authorities. As of May 31, 2025 and 2024, there were no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 6. BENEFIT OBLIGATIONS

The Plan's deficiency of net assets over benefit obligations at May 31, 2025 and 2024, relates primarily to the postretirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current bargaining agreement. It is expected that the deficiency will be funded through future increases in the collectively bargained contribution rates.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point, it would increase the postretirement benefit obligations as of May 31, 2025 and 2024 by \$70,259,149 and \$67,868,162, respectively.



NOTE 7. RELATED PARTY AND PARTY IN INTEREST TRANSACTIONS

Payroll expenses and other general and administrative expenses are shared with the Fox Valley & Vicinity Laborers Pension Fund (Pension Fund) (related party). These costs are allocated between the Plan and the Pension Fund based on methods approved by the Board of Trustees. During the years ended May 31, 2025 and 2024, the Plan paid net expenses on behalf of the Pension Fund totaling \$374,965 and \$396,518, respectively. As of May 31, 2025 and 2024, the Plan owed \$73,035 and \$37,482, respectively, to the Pension Fund. These amounts were paid by the Plan subsequent to the years ended May 31, 2025 and 2024.

The Fox Valley Laborers Health and Welfare Fund entered into a lease with the Fox Valley Laborers Pension Fund Building Corporation (a related party) to rent a portion (59%) of the office building located at 2371 Bowes Road, Suite 500, Elgin, Illinois. The lease requires the Plan to pay monthly payments of \$3,794 through August 31, 2023. Effective September 1, 2023, the monthly payments increased to \$4,002. The current lease term is through August 31, 2026. Either party may terminate this lease at any time upon notifying the other party in writing at least three months prior to the termination date. Total rent expense under the terms of this lease was \$48,025 and \$47,402 for years ended May 31, 2025 and 2024, respectively. In addition, under the terms of the lease, the Fox Valley Laborers Health and Welfare Fund is responsible for its portion (59%) of the utilities, real estate taxes and association fees incurred in connection with the property.

Future minimum lease payments required at May 31, 2025 are as follows:

| <u>Year Ending</u> | <u>Amount</u> |
|--------------------|------------------|
| May 31, 2026 | \$ 48,025 |
| May 31, 2027 | <u>12,006</u> |
| Total | <u>\$ 60,031</u> |

The Plan has elected, for all underlying classes of assets, to not recognize right-of-use assets and lease liabilities for short-term leases that have a lease term of 12 months or less at lease commencement and for leases that are determined to not be enforceable agreements per the guidance in Topic 842. The Plan recognizes lease cost associated with short-term leases on a straight-line basis over the lease term.

In addition, the Plan paid certain expenses related to Plan operations and investment activity to various service providers. These transactions are party in interest transactions under ERISA.



NOTE 8. RISKS AND UNCERTAINTIES

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

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

NOTE 9. PENSION CONTRIBUTIONS

The Plan contributes to a multiemployer defined benefit pension plan under the terms of a participation agreement that covers its employees. The risks of participating in these multiemployer plans are different from single employer plans in the following aspects:

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

The Plan's participation in this plan for the years ended May 31, 2025 and 2024 is outlined in the table on the following page. The "EIN/Plan Number" provides the Employer Identification Number (EIN) and the three-digit plan number, if applicable. The most recent Pension Protection Act (PPA) zone status available in 2025 and 2024 is for the Plan's year-end at May 31, 2025 and 2024, respectively. The zone status is based on information that the Plan received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded. The "FIP/RP Status" indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last section lists the expiration date of the collective bargaining agreement to which the plans are subject. There have been no significant changes that affect the comparability of 2025 and 2024 contributions. The Plan currently has no intention of withdrawing from the multiemployer pension plan in which it participates.

NOTE 9. PENSION CONTRIBUTIONS (CONTINUED)

| | | |
|--|--|---------|
| Pension Fund: | Fox Valley & Vicinity Laborers Pension Fund | |
| EIN/Plan Number: | 36-6147409/001 | |
| Pension Protection Act Zone Status: | | |
| 2025 | Green as of 6/1/25 | |
| 2024 | Green as of 6/1/24 | |
| FIP/RP Status: | N/A | |
| Pension Contributions Made by Fund: | | |
| 2025 | \$ | 408,654 |
| 2024 | \$ | 385,677 |
| Surcharge Imposed: | No | |
| Expiration Date of Collective Bargaining Agreement: | N/A | |

NOTE 10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits from the financial statements to the Form 5500 for the years ended May 31, 2025 and 2024:

| | <u>2025</u> | <u>2024</u> |
|---|-----------------------|-----------------------|
| Net assets available for benefits per the financial statements | \$ 133,143,828 | \$ 128,372,003 |
| Less: current benefit obligations | <u>(29,601,000)</u> | <u>(25,773,000)</u> |
| Net assets available for benefits per Schedule H of Form 5500 | <u>\$ 103,542,828</u> | <u>\$ 102,599,003</u> |

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

| | |
|--|----------------------|
| Total claims paid per the financial statements | \$ 43,267,424 |
| Add: current year benefit obligations | 29,601,000 |
| Less: prior year benefit obligations | <u>(25,773,000)</u> |
| Benefits paid per Schedule H of the Form 5500 | <u>\$ 47,095,424</u> |



**NOTE 10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500
(CONTINUED)**

Claims and premiums that have been processed and approved for payment at year-end, but not paid and claims incurred but not reported are not considered liabilities under GAAP and, therefore, are not presented as liabilities or claims and premiums paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

The following is a reconciliation of additions and deductions per the statement of changes in net assets available for benefits to income and expenses per the Form 5500 for the year ended May 31, 2025.

| | |
|--|----------------------|
| Total additions per statement of changes in net assets available for benefits | \$ 51,415,366 |
| Investment expenses | <u>554,007</u> |
| Total income per the Form 5500 | <u>\$ 51,969,373</u> |
| | |
| Total deductions per statement of changes in net assets available for benefits | \$ 46,643,541 |
| Change in current benefit obligations | 3,828,000 |
| Investment expenses | <u>554,007</u> |
| Total expenses per the Form 5500 | <u>\$ 51,025,548</u> |

NOTE 11. SUBSEQUENT EVENTS

Subsequent events have been evaluated through January 15, 2026, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.



SUPPLEMENTAL INFORMATION





**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

SCHEDULES OF GENERAL AND ADMINISTRATIVE EXPENSES

YEARS ENDED MAY 31, 2025 AND 2024

| | 2025 | 2024 |
|--|--------------|--------------|
| General and administrative expenses (net of reimbursements) | | |
| Depreciation expense | \$ 6,377 | \$ 8,092 |
| Dues and subscriptions | 5,169 | 4,968 |
| Employee benefits | 447,701 | 418,368 |
| Insurance - general | 40,897 | 40,529 |
| Payroll taxes | 43,930 | 43,619 |
| Payroll service fees | 7,606 | 7,211 |
| Postage | 71,681 | 63,788 |
| Printing and office expense | 219,450 | 208,831 |
| Professional fees | | |
| - Administrative accounting | 4,550 | 3,114 |
| - Audit | 24,365 | 23,000 |
| - Computer consulting | 9,146 | 6,461 |
| - Consulting | 237,433 | 225,267 |
| - Payroll audit | 51,242 | 75,733 |
| - Legal (collections) | 19,051 | 20,454 |
| - Legal (general) | 68,318 | 68,325 |
| Rent and occupancy expense | 93,708 | 85,142 |
| Salaries and wages | 504,119 | 480,315 |
| Seminars, conferences and meetings | 18,113 | 20,042 |
| Telephone expense | 6,477 | 6,483 |
| Total general and administrative expenses | \$ 1,879,333 | \$ 1,809,742 |

FOX VALLEY LABORERS HEALTH AND WELFARE FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

MAY 31, 2025

Form 5500, Schedule H, Part IV, Line 4(f)

EIN 36-6219639
Plan No. 001

| (a) | (b) Identity of Issuer, Borrower, Lessor, or Similar Party | (c) Description of Investment Including Maturity Date, Rate of Interest, Shares or Par/Maturity Value | | | (d) Cost | (e) Current Value |
|-----|---|--|---------------------|---|-----------------------|-------------------------|
| | Description | Maturity Date | Rate of Interest | Number of Shares or Par/ Maturity Value | | |
| | <u>Registered investment companies</u> | | | | | |
| | SEI Inst Inv Core Fixed Income Fund | Registered investment co. | N/A | N/A | 3,123,565 | \$ 31,007,126 |
| | SEI Inst Inv High Yield Bond Fund | Registered investment co. | N/A | N/A | 358,592 | 2,939,416 |
| | SEI Inst Inv Limited Duration Bond Fund | Registered investment co. | N/A | N/A | 2,336,358 | 22,907,513 |
| | SEI Inst Inv Opportunities Income Fund | Registered investment co. | N/A | N/A | 780,148 | 6,309,778 |
| | SEI Inst Inv Small/Mid Cap Equity Fund | Registered investment co. | N/A | N/A | 249,502 | 2,722,721 |
| | SEI Inst Inv Trust Dynamic Asset Allocation Fund | Registered investment co. | N/A | N/A | 203,444 | 3,978,298 |
| | SEI Inst Inv Trust Emerging Markets Debt Fund | Registered investment co. | N/A | N/A | 288,638 | 2,741,168 |
| | SEI Inst Inv Trust Multi-Asset Real Return Fund | Registered investment co. | N/A | N/A | 1,185,084 | 9,595,657 |
| | SEI Inst Inv Trust Real Return Fund | Registered investment co. | N/A | N/A | 930,756 | 8,741,528 |
| | SEI Inst Inv Ultra Short Duration Bond Fund | Registered investment co. | N/A | N/A | 878,452 | 8,753,694 |
| | SEI Inst Inv S&P 500 Index Fund | Registered investment co. | N/A | N/A | 375,538 | 6,788,376 |
| | SEI Inst Inv Extended Market Index Fund | Registered investment co. | N/A | N/A | 139,125 | 2,223,810 |
| | SEI Inst U.S. Equity Factor Allocation Fund | Registered investment co. | N/A | N/A | 428,971 | 5,063,029 |
| | SEI Inst Inv World Equity Ex-US Fund | Registered investment co. | N/A | N/A | 1,135,085 | 13,670,721 |
| | Total registered investment companies | | | | <u>127,442,835</u> | <u>125,368,605</u> |
| | <u>Cash equivalents</u> | | | | | |
| | Northern Institutional Government Funds Portfolio | Cash equivalent | N/A | N/A | 3,639,659 | 3,639,659 |
| | Total assets (held at end of year) | | | | <u>\$ 131,082,494</u> | <u>\$ 129,008,264</u> |



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED MAY 31, 2025

Form 5500, Schedule H, Part IV, Line 4(j)

EIN 36-6219639
Plan No. 001

| (b) Description of Asset | (c) Purchase Price | (d) Selling Price | (g) Cost of Asset | (h) Current Value of Asset at Transaction Date | (i) Net Gain (Loss) |
|---|--------------------------|-------------------------|-------------------------|--|------------------------|
| <u>Cash equivalents</u> | | | | | |
| Northern Institutional Government Funds Portfolio | \$ 52,664,638 | \$ - | \$ 52,664,638 | \$ 52,664,638 | \$ - |
| | - | 49,727,240 | 49,727,240 | 49,727,240 | - |

FOX VALLEY LABORERS HEALTH AND WELFARE FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

MAY 31, 2025

Form 5500, Schedule H, Part IV, Line 4(f)

EIN 36-6219639
Plan No. 001

| (a) | (b) Identity of Issuer, Borrower, Lessor, or Similar Party | (c) Description of Investment Including Maturity Date, Rate of Interest, Shares or Par/Maturity Value | | | (d) Cost | (e) Current Value |
|-----|---|--|---------------------|---|-----------------------|-------------------------|
| | Description | Maturity Date | Rate of Interest | Number of Shares or Par/ Maturity Value | | |
| | <u>Registered investment companies</u> | | | | | |
| | SEI Inst Inv Core Fixed Income Fund | Registered investment co. | N/A | N/A | 3,123,565 | \$ 31,007,126 |
| | SEI Inst Inv High Yield Bond Fund | Registered investment co. | N/A | N/A | 358,592 | 2,939,416 |
| | SEI Inst Inv Limited Duration Bond Fund | Registered investment co. | N/A | N/A | 2,336,358 | 22,907,513 |
| | SEI Inst Inv Opportunities Income Fund | Registered investment co. | N/A | N/A | 780,148 | 6,309,778 |
| | SEI Inst Inv Small/Mid Cap Equity Fund | Registered investment co. | N/A | N/A | 249,502 | 2,722,721 |
| | SEI Inst Inv Trust Dynamic Asset Allocation Fund | Registered investment co. | N/A | N/A | 203,444 | 3,978,298 |
| | SEI Inst Inv Trust Emerging Markets Debt Fund | Registered investment co. | N/A | N/A | 288,638 | 2,741,168 |
| | SEI Inst Inv Trust Multi-Asset Real Return Fund | Registered investment co. | N/A | N/A | 1,185,084 | 9,595,657 |
| | SEI Inst Inv Trust Real Return Fund | Registered investment co. | N/A | N/A | 930,756 | 8,741,528 |
| | SEI Inst Inv Ultra Short Duration Bond Fund | Registered investment co. | N/A | N/A | 878,452 | 8,753,694 |
| | SEI Inst Inv S&P 500 Index Fund | Registered investment co. | N/A | N/A | 375,538 | 6,788,376 |
| | SEI Inst Inv Extended Market Index Fund | Registered investment co. | N/A | N/A | 139,125 | 2,223,810 |
| | SEI Inst U.S. Equity Factor Allocation Fund | Registered investment co. | N/A | N/A | 428,971 | 5,063,029 |
| | SEI Inst Inv World Equity Ex-US Fund | Registered investment co. | N/A | N/A | 1,135,085 | 13,670,721 |
| | Total registered investment companies | | | | <u>127,442,835</u> | <u>125,368,605</u> |
| | <u>Cash equivalents</u> | | | | | |
| | Northern Institutional Government Funds Portfolio | Cash equivalent | N/A | N/A | 3,639,659 | 3,639,659 |
| | Total assets (held at end of year) | | | | <u>\$ 131,082,494</u> | <u>\$ 129,008,264</u> |

| | | |
|---|---|--|
| Form 5500 Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> 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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | OMB Nos. 1210 - 0110 1210 - 0089 <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> <hr/> This Form is Open to Public Inspection |
|---|---|--|

| | |
|--|--|
| Part I Annual Report Identification Information | |
| For calendar plan year 2024 or fiscal plan year beginning <u>06/01/2024</u> and ending <u>05/31/2025</u> | |
| A This return/report is for: | <input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months) |
| C If the plan is a collectively-bargained plan, check here | <input checked="" type="checkbox"/> |
| D Check box if filing under: | <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description) |
| E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here | <input type="checkbox"/> |

| | | | | | | | | | | | |
|---|---|--|------------|--|--|--|--|---|--|--|--|
| Part II Basic Plan Information - enter all requested information | | | | | | | | | | | |
| 1a Name of plan FOX VALLEY LABORERS HEALTH & WELFARE FUND | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">1b Three-digit plan number (PN) ▶</td> <td style="text-align: center;">501</td> </tr> <tr> <td colspan="2">1c Effective date of plan 10/01/1968</td> </tr> <tr> <td colspan="2">2b Employer Identification Number (EIN) 36-6219639</td> </tr> <tr> <td colspan="2">2c Plan Sponsor's telephone number 847-742-0900</td> </tr> <tr> <td colspan="2">2d Business code (see instructions) 237310</td> </tr> </table> | 1b Three-digit plan number (PN) ▶ | 501 | 1c Effective date of plan 10/01/1968 | | 2b Employer Identification Number (EIN) 36-6219639 | | 2c Plan Sponsor's telephone number 847-742-0900 | | 2d Business code (see instructions) 237310 | |
| 1b Three-digit plan number (PN) ▶ | 501 | | | | | | | | | | |
| 1c Effective date of plan 10/01/1968 | | | | | | | | | | | |
| 2b Employer Identification Number (EIN) 36-6219639 | | | | | | | | | | | |
| 2c Plan Sponsor's telephone number 847-742-0900 | | | | | | | | | | | |
| 2d Business code (see instructions) 237310 | | | | | | | | | | | |
| 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) TRUSTEES OF FOX VALLEY LABORERS HEALTH AND WELFARE 2371 BOWES ROAD, STE 500 ELGIN IL 60123-5523 | | | | | | | | | | | |

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 | | 1/27/24 | <i>SECRETARY</i> Brian Urso |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | 1/27/24 | <i>Treasurer</i> Brian Rausch |
| | 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 |

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Form 5500 (2024) v. 240311

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

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

| | | |
|---|--------------|-------|
| 5 Total number of participants at the beginning of the plan year | 5 | 2,075 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). | | |
| a (1) Total number of active participants at the beginning of the plan year | 6a(1) | 1,513 |
| a (2) Total number of active participants at the end of the plan year | 6a(2) | 1,418 |
| b Retired or separated participants receiving benefits | 6b | 583 |
| c Other retired or separated participants entitled to future benefits | 6c | |
| d Subtotal. Add lines 6a(2), 6b, and 6c | 6d | 2,001 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e | |
| f Total. Add lines 6d and 6e | 6f | |
| g (1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | 6g(1) | |
| (2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g(2) | |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | 184 |

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

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

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

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

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



**FOX VALLEY LABORERS
HEALTH AND WELFARE FUND**

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED MAY 31, 2025

Form 5500, Schedule H, Part IV, Line 4(j)

EIN 36-6219639
Plan No. 001

| (b) Description of Asset | (c) Purchase Price | (d) Selling Price | (g) Cost of Asset | (h) Current Value of Asset at Transaction Date | (i) Net Gain (Loss) |
|---|--------------------------|-------------------------|-------------------------|--|------------------------|
| <u>Cash equivalents</u> | | | | | |
| Northern Institutional Government Funds Portfolio | \$ 52,664,638 | \$ - | \$ 52,664,638 | \$ 52,664,638 | \$ - |
| | - | 49,727,240 | 49,727,240 | 49,727,240 | - |