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| <p>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>Annual Return/Report of Employee Benefit Plan</p> <p>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> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

| | |
|---|--|
| <p>1a Name of plan <u>OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>501</u></p> |
| <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN</u></p> <p><u>C/O BOARD OF TRUSTEES</u> <u>1180 DUBLIN ROAD</u> <u>COLUMBUS, OH 43215-7003</u></p> | <p>1c Effective date of plan <u>03/11/1960</u></p> <p>2b Employer Identification Number (EIN) <u>31-4446857</u></p> <p>2c Plan Sponsor's telephone number <u>614-488-0708</u></p> <p>2d Business code (see instructions) <u>237990</u></p> |

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

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

| | | | |
|------------------|---|------------|--|
| SIGN HERE | Filed with authorized/valid electronic signature. | 02/18/2026 | CAROL A. WILSON |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 02/20/2026 | ROBERT L. HUGHES |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

| | | |
|---|--|-------|
| 3a Plan administrator's name and address <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 | 13389 |
| 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) | 9887 |
| | 6a(2) | 10314 |
| | 6b | 3358 |
| | 6c | |
| | 6d | 13672 |
| | 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 | 1096 |

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

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

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

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

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

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

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

Receipt Confirmation Code _____

| | | |
|--|--|---|
| SCHEDULE 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 **08/01/2024** and ending **07/31/2025**

| | | |
|--|--|------------|
| A Name of plan OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN | D Employer Identification Number (EIN) 31-4446857 | |

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)

ANTHEM BLUE CROSS AND BLUE SHIELD

31-1440175

| (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 | | 4093169 | 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)

STONER & ASSOCIATES INC.

31-1219231

| (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 | | 1060098 | 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)

AMERICAN HEALTH HOLDING, INC.

31-1368946

| (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 | | 559739 | 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)

LOOMIS, SAYLES & COMPANY

ONE FINANCIAL CENTER
BOSTON, MA 02111

| (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 | | 303230 | 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)

LIFELINE SCREENING

901 SOUTH MOPAC EXPRESSWAY
AUSTIN, TX 78746

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 150284 | 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)

LEDBETTER PARTNERS LLC

03-0599899

| (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 | | 126224 | 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)

MCGAFFE, TRACY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 84019 | 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)

WILSON, CAROL

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 81808 | 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)

BLUETEAM NETWORKS

81-4198762

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 78127 | 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)

TOLLEY, TIMOTHY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 77506 | 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)

DAWSON RESOURCES

31-0890517

| (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 | | 63587 | 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)

C&P ADVISORS LLC

34-1322309

| (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 | | 63370 | 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)

BARKER, STACEY J.

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 59464 | 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)

WISE-MILLER, SHERRY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 55832 | 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)

STARKEY, DANIELLE

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 53517 | 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)

CRAMER, JAMES

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 50193 | 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)

HELMICK, JUSTIN S.

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 49221 | 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)

BISCIOTTI, ASHLEY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 45465 | 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)

PULLINS, KIM

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 43975 | 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)

LULI, BRADEN

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 40025 | 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)

SOLTESZ, TROY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 39522 | 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)

EXECU-CLEAN

20-0859748

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 38963 | 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)

MARTIN, SUSAN

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 32912 | 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)

AON

27-2436452

| (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 | | 32288 | 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)

CAREMARK PRESCRIPTION SERVICE

36-4268991

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 | | 32115 | 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)

ROSE, GRACE

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 28578 | 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)

MCINTOSH, LISA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 28220 | 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)

ENVIRONMENTAL MANAGEMENT

31-1386050

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 28105 | 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)

GERSPER, TARA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 26414 | 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)

KIRK, JEANA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 25773 | 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)

HANNA, MELISSA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 24449 | 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)

GORDON, TERRY L.

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 24444 | 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)

GARWOOD, JUDY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 23996 | 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)

SCOTT, STEPHANIE

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 23087 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

THE SEGAL COMPANY

13-1975125

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 11 | | 23000 | 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)

BOEHMER, AMELIA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 22580 | 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)

SCOTT, JESSICA

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 22238 | 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)

EBBELER, SUSAN

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 22062 | 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)

HEISLER, GRETCHEN

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 21780 | 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)

BLACKROCK

94-0288125

| (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? |
|------------------------|---|--|--|--|---|--|
| 21 | | 18714 | 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)

GEIGER BROTHERS INC.

31-0733949

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 16008 | 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)

ORRAND, RAY

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 15000 | 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)

JP MORGAN

31-4148768

| (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? |
|------------------------|---|--|--|--|---|--|
| 26 | | 12600 | 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)

HYLANT GROUP

34-1880366

| (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? |
|------------------------|---|--|--|--|---|--|
| 73 | | 11050 | 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)

LARRY S. PARSONS

19540 CLARKS RUN RD
MOUNT STERLING, OH 43143-9202

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 10790 | 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)

HARD FIRE SUPPRESSION INC.

31-1256611

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 10720 | 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)

WENNSOFT INC.

39-1950131

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 8819 | 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)

BUCKINGHAM, LAURA E.

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 7771 | 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)

RUMPKE OF OHIO INC

31-1617611

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 5658 | 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)

DORNEY, SUSAN

31-4446857

| (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? |
|------------------------|---|--|--|--|---|--|
| 35 | EMPLOYEE | 5516 | 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)

W W WILLIAMS COMPANY LLC

81-3158413

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 5463 | 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)

CINTAS

31-1188630

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 | | 5093 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

| | | |
|---|--|---|
| SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> | DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection. |
|---|--|---|

For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025

| | | |
|---|--|------------|
| A Name of plan <u>OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN</u> | B Three-digit plan number (PN) | <u>501</u> |
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN</u> | D Employer Identification Number (EIN) <u>31-4446857</u> | |

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

| | | |
|--|-------------------------------|---|
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>U.S. EQUITY MARKET FUND B</u> | | |
| b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY, N.A.</u> | | |
| c EIN-PN <u>94-3112180-000</u> | d Entity code <u>C</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>37915316</u> |
| a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI ACWI EX-US IMI INDEX FUND B</u> | | |
| b Name of sponsor of entity listed in (a): <u>BLACKROCK INSTITUTIONAL TRUST COMPANY, N.A.</u> | | |
| c EIN-PN <u>94-3112180-000</u> | d Entity code <u>C</u> | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>29671523</u> |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | | |
| b Name of sponsor of entity listed in (a): | | |
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | | |
| b Name of sponsor of entity listed in (a): | | |
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | | |
| b Name of sponsor of entity listed in (a): | | |
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | | |
| b Name of sponsor of entity listed in (a): | | |
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | | |
| b Name of sponsor of entity listed in (a): | | |
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

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

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

c EIN-PN

d Entity code

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

| | | |
|--|--|---|
| SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | OMB No. 1210-0110 2024 This Form is Open to Public Inspection |
|--|--|---|

| | |
|--|--|
| For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025 | |
| A Name of plan OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN | D Employer Identification Number (EIN) 31-4446857 |

| | |
|---------------|--------------------------------------|
| 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 394590 | 424367 |
| b Receivables (less allowance for doubtful accounts): | | |
| (1) Employer contributions | 1b(1) 15741138 | 18165532 |
| (2) Participant contributions | 1b(2) | |
| (3) Other | 1b(3) 7296582 | 7880068 |
| c General investments: | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) 11600940 | 21197164 |
| (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) 55807577 | 67586839 |
| (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) 73245302 | 73435697 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | |
| (15) Other | 1c(15) 1200711 | 1473387 |

| 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 | | |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 165286840 | 190163054 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | 4166455 | 4854579 |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 203570378 | 234524221 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 207736833 | 239378800 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | -42449993 | -49215746 |

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) | 174443082 | |
| (B) Participants..... | 2a(1)(B) | 12353982 | |
| (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) | | 186797064 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 755253 | |
| (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) | | 755253 |
| (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) | 2870624 | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 2870624 |
| (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) | | 8785326 |
| (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) | | 747193 |
| c Other income | 2c | | -30306371 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 169649089 |

Expenses

| | | | |
|---|---------------|-----------|-----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 173466747 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | | |
| (3) Other | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 173466747 |
| 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) | 1059544 | |
| (2) Contract administrator fees | 2i(2) | | |
| (3) Recordkeeping fees | 2i(3) | | |
| (4) IQPA audit fees | 2i(4) | 63370 | |
| (5) Investment advisory and investment management fees | 2i(5) | 334544 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | 17851 | |
| (7) Actuarial fees | 2i(7) | | |
| (8) Legal fees | 2i(8) | 131861 | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | 1737 | |
| (11) Other expenses | 2i(11) | 1339188 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 2948095 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 176414842 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|----------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | -6765753 |
| 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: **CIUNI & PANICHI, INC.**

(2) EIN: **34-1322309**

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 | | 2500000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | X | |
| g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | X | | |
| j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) | X | | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | | X | |
| l Has the plan failed to provide any benefit when due under the plan? | | X | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | | |
| n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. | | | |

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

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

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

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

Where Relationships Count.

Independent Auditor's Report

Board of Trustees
Ohio Operating Engineers Health and Welfare Plan

Opinion

We have audited the financial statements of Ohio Operating Engineers Health and Welfare Plan (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 as of July 31, 2025 and 2024, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits of the Plan as of July 31, 2025 and 2024, and the changes in its net assets available for benefits for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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Board of Trustees
Ohio Operating Engineers Health and Welfare Plan

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Board of Trustees
Ohio Operating Engineers Health and Welfare Plan

Supplemental Schedules Required by ERISA and Other Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of Statements of Operating Expenses, for the years ended July 31, 2025 and 2024 and of Statement of Investments and Investment Income by Investment Manager, as of and for the year ended July 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements. The ERISA-required supplemental schedules of Schedule H, Line 4i – Schedule of Assets (Held at End of Year), as of July 31, 2025 and of Schedule H, Line 4j – Schedule of Reportable Transactions, for the year ended July 31, 2025 are also presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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



Cleveland, Ohio
January 16, 2026

**Ohio Operating Engineers
 Health and Welfare Plan**

Statements of Net Assets Available for Benefits

July 31, 2025 and 2024

| | <u>Assets</u> | |
|--|-----------------------|-----------------------|
| | <u>2025</u> | <u>2024</u> |
| Investments, at fair value: | | |
| Common collective trust funds | \$ 67,586,839 | \$ 55,807,577 |
| Exchange traded fund | 36,289,330 | - |
| Mutual funds | 37,146,367 | 73,245,302 |
| Money market funds | 21,197,164 | 11,600,940 |
| Total investments | <u>162,219,700</u> | <u>140,653,819</u> |
| Receivables: | | |
| Employers' contributions | 18,165,532 | 15,741,138 |
| Claims rebates and stop loss refunds | 5,570,192 | 4,340,921 |
| Due from other Ohio Operating Engineers benefit funds, net | 2,238,263 | 2,913,690 |
| Accrued interest | 71,613 | 41,971 |
| Total receivables | <u>26,045,600</u> | <u>23,037,720</u> |
| Cash | 424,367 | 394,590 |
| Benefit asset - staff pension plan | 1,473,387 | 1,200,711 |
| Total assets | <u>190,163,054</u> | <u>165,286,840</u> |
| | <u>Liabilities</u> | |
| Accounts payable and accrued expenses | <u>4,854,579</u> | <u>4,166,455</u> |
| Total liabilities | <u>4,854,579</u> | <u>4,166,455</u> |
| Net assets available for benefits | <u>\$ 185,308,475</u> | <u>\$ 161,120,385</u> |

The accompanying notes are an integral part of these financial statements

Ohio Operating Engineers Health and Welfare Plan

Statements of Changes in Net Assets Available for Benefits

For the years ended July 31, 2025 and 2024

| | 2025 | 2024 |
|---|----------------|----------------|
| Additions: | | |
| Investment income: | | |
| Interest | \$ 761,243 | \$ 546,726 |
| Dividends | 2,870,624 | 3,103,442 |
| Net appreciation in fair value of investments | 9,526,529 | 9,784,551 |
| | 13,158,396 | 13,434,719 |
| Less: investment expense | (334,544) | (333,286) |
| Net investment income | 12,823,852 | 13,101,433 |
| Contributions: | | |
| Employers' | 174,443,082 | 162,940,488 |
| Members' | 12,353,982 | 12,608,072 |
| Total contributions | 186,797,064 | 175,548,560 |
| Late charges | 102,125 | 80,981 |
| Other income | 293,312 | 658,222 |
| Total additions | 200,016,353 | 189,389,196 |
| Deductions: | | |
| Claims and insurance premiums paid for health benefits, net | 168,469,927 | 174,761,256 |
| Claims and prescription administration | 4,996,820 | 4,840,534 |
| Health care education | 126,616 | 167,744 |
| Operating expenses | 2,486,935 | 2,101,761 |
| Total deductions | 176,080,298 | 181,871,295 |
| Net increase before net gain on staff pension plan | 23,936,055 | 7,517,901 |
| Net gain on staff pension plan | 252,035 | 638,185 |
| Net increase | 24,188,090 | 8,156,086 |
| Net assets available for benefits: | | |
| Beginning of year | 161,120,385 | 152,964,299 |
| End of year | \$ 185,308,475 | \$ 161,120,385 |

The accompanying notes are an integral part of these financial statements

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 1: Description of the Plan

The following description of Ohio Operating Engineers Health and Welfare Plan (the “Plan”) provides only general information about the Plan’s provisions. Participants should refer to the plan agreement for a complete description of the Plan’s provisions.

General

The Plan is a multiemployer defined benefit health and welfare plan that was established on March 11, 1960, as a result of collective bargaining agreements (CBA) between International Union of Operating Engineers, Local 18 and its branches (“Local 18”); and The Ohio Contractors Association, Distribution and Maintenance Employers, The AGC of Ohio, and Construction Employers Association. The Plan is governed by a joint board consisting of equal representation from the participating employers and Local 18. The Plan provides benefits for eligible participants and their dependents and is subject to the provisions of the Employee Retirement Income Security Act 1974 (ERISA), as amended. Plan assets are held in a voluntary employees’ beneficiary association (VEBA) trust.

Eligibility

To become initially eligible for benefits, a participant must meet the eligibility criteria of the applicable member class, as defined in the plan agreement. The Plan has the following member classes:

- Class 1 – Members who are operating engineers and work for employers within the geographic and work jurisdiction of Local 18, 18A, 18B, 18C, or 18RA who are required to contribute to the Plan on their behalf;
- Class 2 – Members who are full-time employees of Local 18, 18A, 18B, 18C, or 18RA; Ohio Operating Engineers Apprenticeship and Training Fund; or the Plan;
- Class 3A – Senior members who meet service requirements defined in the plan agreement, are retired, under age 65, and who make the required monthly payments to the Plan in order to continue coverage;
- Class 3C – Senior members age 65 and over who meet service requirements defined in the plan agreement and were either age 65 or older at the time of their retirement, or who participated as a Class 3A until they reached age 65;
- Class 5 – Non-operating employees of employers obligated to contribute on their behalf under a non-operating employees’ participation agreement; and
- Class 6 – Members who qualified for permanent and total disability before they qualified for the senior member program; and meet service requirements defined in the plan agreement.

Once the eligibility requirements are met, certain eligible dependents are also covered under the Plan upon submission of the applicable enrollment form and supporting documents to the Plan Administrator.

Generally, a participant will remain eligible as long as actively employed with a participating employer. Participants may also continue to remain eligible for benefits through the use of accumulated eligibility credits for times of unemployment (less than full time), and then through self-contributions, and upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 1: Description of the Plan (continued)

Contributions

Under the terms of CBAs, participating employers contribute various amounts based on the employee's classification. The contribution rate is dependent upon the collective bargaining agreement that the employer is signatory to. Unemployed and underemployed members may maintain coverage by utilizing the members' credited reserve hours, until depleted, and then through self-contributions, based on criteria established by the plan agreement. Retirees must make self-contributions to continue receiving benefits under the Plan. Contributions required by retirees are determined in accordance with the levels established by the Plan's Board of Trustees.

Benefits

The Plan provides health benefits (medical and prescription drugs), short-term disability benefits, and accidental death and dismemberment benefits. Retired employees are entitled to similar health benefits (in excess of Medicare coverage). The Plan also provides continuation of certain benefits upon termination of employment through COBRA.

Insured Benefits

The Plan provides medical benefits coverage to retired participants receiving Medicare benefits and their covered dependents pursuant to a policy of insurance issued by a third-party health insurance provider. In addition, the Plan purchases stop loss insurance to actively manage catastrophic medical claims.

Self-insured Benefits

All other plan benefits are self-insured. The claims for self-insured benefits (other than short-term disability benefits and accidental death and dismemberment benefits) are processed by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the Plan. Ultimate responsibility for payments to providers and participants is retained by the Plan. The Plan uses a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs.

Basis of Accounting and Use of Estimates

The accompanying financial statements have been prepared using the accrual basis of accounting. The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America (GAAP) 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.

Basis of Presentation

The Plan follows authoritative guidance issued by the Financial Accounting Standards Board (FASB), which established the FASB Accounting Standards Codification (ASC) as the single source of authoritative accounting principles generally accepted in the United States of America.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 2: Summary of Significant Accounting Policies

Investment Valuation and Income Recognition

Investments are reported 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. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by investment professionals. See Note 5 for discussion of fair value measurements. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) in fair value of investments includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Securities Lending

The Plan is authorized to engage in the lending of certain investments. Securities lending is an investment management enhancement that utilizes certain existing securities of the Plan to earn additional income. Securities lending involves the loaning of securities to approved banks and broker/dealers. In return for the loaned securities, the Plan, prior to or simultaneous with delivery of the loaned securities to the borrower, receives collateral in the form of cash, securities issued by the U.S. government and its agencies, or letters of credit as a safeguard against possible default of any borrower on the return of the loan under terms that permit the Plan to re-pledge or sell the securities.

Each loan is initially collateralized, in the case of: (a) loaned securities denominated in U.S. dollars or whose primary trading market is located in the U.S., or (b) loaned securities not denominated in U.S. dollars or whose primary trading market is not located in the U.S. to the extent of 102% of the market value of the loaned securities. The collateral is marked to market on a daily basis. In the event the counterparty is unable to meet its contractual obligation under the securities lending arrangement, the Plan may incur losses equal to the amount by which the market value of the securities differ from the amount of collateral held.

The Plan mitigates credit risk associated with securities lending arrangements by monitoring the fair value of the securities loaned on a regular basis, with additional collateral obtained or refunded as necessary. The Plan did not participate in any securities lending activity during the years ended July 31, 2025 and 2024.

Employers' Contributions Receivable

The Plan's policy is to recognize contributions based on the latest executed CBA on an individual employer basis. Contributions from participating employers are based on hours worked by covered employees and are payable to the Plan during the subsequent month. Contributions due but not paid prior to year-end are recorded as employers' contributions receivable in the accompanying statements of net assets available for benefits. Employer contributions receivable represent amounts due from employers that were received subsequent to year-end. Therefore, the carrying amount of these receivables is not reduced by an allowance for amounts that will not be collected. In addition, it is impractical to estimate a recognition of revenue amounts due but erroneously unreported by employers.

Cash

The Plan maintains its cash accounts at a national financial institution. The balances, at times, may exceed federally insured limits.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 2: Summary of Significant Accounting Policies (continued)

Payment of Benefits

Premiums are recorded as claims and insurance premiums paid for health benefits in the accompanying statements of changes in net assets available for benefits, when paid. Claim payments are recorded when submitted to the Plan by the third-party claims processor for reimbursement. Claims paid by the claims processor prior to year-end or claim payments submitted to the Plan by the third-party claims processor that are not yet paid are recorded as an amount currently payable and are included in accounts payable and accrued expenses in the accompanying statements of net assets available for benefits. Short-term disability and accidental death and dismemberment payments are processed by the Plan. These payments are recorded as claims and insurance premiums paid for health benefits in the accompanying statements of changes in net assets available for benefits, when paid.

Refunds and Rebates

Prescription refunds due from the Plan's PBM are recorded when earned. Refunds due at year-end are recorded as a receivable on the accompanying statements of net assets available for benefits, with the offset netted against claims and insurance premiums paid for health benefits. Pharmacy rebates totaling \$20,970,576 and \$15,130,838 have been netted with claims and insurance premiums paid for health benefits in the accompanying statements of changes in net assets available for benefits for the years ended July 31, 2025 and 2024, respectively.

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 claims and insurance premiums paid for health benefits in the accompanying statements of changes in net assets available for benefits. Stop-loss refunds totaling \$39,250 and \$373,213 during the years ended July 31, 2025 and 2024, respectively, have been netted with claims and insurance premiums paid for health benefits in the accompanying statements of changes in net assets available for benefits.

Operating Expenses

Expenses incurred in connection with the general administration of the Plan are recorded as deductions in the accompanying statements of changes in net assets available for benefits. The Plan shares certain administrative expenses with other related plans. In computing these allocated costs, various factors were considered, including the time spent, space used, costs incurred, and volume of transactions relating to the Plan in relation to the various other plans (see Note 11). Certain investment related expenses are included in net appreciation (depreciation) in fair value of investments in the accompanying statements of changes in net assets available for benefits.

Subsequent Events

Management has evaluated subsequent events for the Plan through January 16, 2026, the date the financial statements were available to be issued.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 3: Postretirement Benefit Obligations and Accumulated Eligibility Credits

A postretirement benefit obligation has been recognized for future benefits expected to be paid to or for (1) currently retired participants and their beneficiaries and dependents, and (2) active participants and their beneficiaries and dependents after retirement from service with the participating employers. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to participant 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 retirees of the Plan. The obligations represent the amounts that are expected to be funded by contributions from the participating employers and from existing assets of the Plan. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributable to that employee's service with a participating employer or employers rendered to the valuation date.

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 Plan is required to provide benefits to certain members, if such members have accumulated credit amounts (expressed in dollars) in excess of that required for current coverage. Participants draw on their accumulated credits whenever they fail to meet the annual requirement. The estimated future liability represents the present value of an extension of future benefits that occurs prior to eligibility for retirement with medical benefits per the rules specified in the plan agreement. The calculation of the accumulated eligibility credit reserves at July 31, 2025 and 2024, have been based on information provided by the Plan's management to the actuary.

The following table presents the components of the Plan's benefit obligations at July 31:

| | 2025 | 2024 |
|--|-------------|-------------|
| Amounts currently payable: | | |
| Health claims and death benefits payable | \$ - | \$ - |
| Other obligations for current benefit coverage, at present value of estimated amounts: | | |
| Claims incurred but not reported | 22,705,400 | 16,179,800 |
| Accumulated eligibility credits | 158,034,700 | 136,270,200 |
| Medical reimbursement accounts | 53,784,121 | 51,120,378 |
| Total obligations other than postretirement benefit obligations | 234,524,221 | 203,570,378 |

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 3: Postretirement Benefit Obligations and Accumulated Eligibility Credits (continued)

| | 2025 | 2024 |
|--|--------------------|--------------------|
| Postretirement benefit obligations: | | |
| Current retirees | 67,827,790 | 53,815,846 |
| Other participants fully eligible for benefits | 33,815,850 | 61,780,400 |
| Other participants not yet fully eligible for benefits | 63,438,924 | 54,840,240 |
| Total postretirement benefit obligations | 165,082,564 | 140,436,486 |
| Plan's total benefit obligations | \$ 399,606,785 | \$ 344,006,864 |

The following tables present the changes in the Plan's benefit obligations for the years ended July 31:

| | 2025 | 2024 |
|--|--------------------|--------------------|
| Amounts currently payable: | | |
| Health claims and death benefits payable, beginning of year | \$ - | \$ - |
| Claims and insurance premiums approved for payment | 168,469,927 | 174,761,256 |
| Claims and insurance premiums paid | (168,469,927) | (174,761,256) |
| Health claims and death benefits payable, end of year | - | - |
| Other obligations for current benefit coverage, at present value of estimated amounts: | | |
| Balance, beginning of year | 203,570,378 | 178,425,779 |
| Net change during the year from: | | |
| Claims incurred but not reported | 6,525,600 | 3,249,800 |
| Accumulated eligibility credits | 21,764,500 | 17,982,500 |
| Medical reimbursement accounts | 2,663,743 | 3,912,299 |
| Balance, end of year | 234,524,221 | 203,570,378 |
| Postretirement benefit obligations: | | |
| Balance, beginning of year | 140,436,486 | 118,343,541 |
| Benefits earned net of benefits paid | 5,089,058 | 4,405,210 |
| Actuarial experience loss | 1,563,205 | - |
| Changes in actuarial assumptions | 17,993,815 | 17,687,735 |
| Balance, end of year | 165,082,564 | 140,436,486 |
| Plan's total benefit obligations | \$ 399,606,785 | \$ 344,006,864 |

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 3: Postretirement Benefit Obligations and Accumulated Eligibility Credits (continued)

The following is a summary of significant actuarial assumptions used in determining the postretirement benefit obligations for the years ended July 31:

| | 2025 | 2024 |
|--------------------------------------|--|--|
| Discount rate | 5.50% | 5.00% |
| Health care trend rates: | | |
| Non-Medicare | 8.25% graded to 4.50% over 11 years | 7.75% graded to 4.50% over 11 years |
| Medicare | 9.75% graded to 4.50% over 11 years | 39.00% for one year, then 8.50% graded to 4.50% over 10 years |
| Mortality: | | |
| Healthy | Pri-2012 Blue Collar Headcount-weighted Healthy Annuitant Mortality Table Projected generationally from 2012 with Scale MP-2020 | Pri-2012 Blue Collar Headcount-weighted Healthy Annuitant Mortality Table Projected generationally from 2012 with Scale MP-2020 |
| Disabled | Pri-2012 Headcount-weighted Disabled Retiree Mortality Table projected generationally from 2012 with Scale MP 2020 | Pri-2012 Headcount-weighted Disabled Retiree Mortality Table projected generationally from 2012 with Scale MP 2020 |
| Administrative expense increase rate | 3.00% | 3.00% |
| Retiree contribution increase rate: | | |
| Non-Medicare | 8.25% graded to 4.50% over 11 years | 7.75% graded to 4.50% over 11 years |
| Medicare | 4.50% | 4.50% |

The weighted-average health care cost trend rate assumption has a significant effect on the amounts reported as postretirement benefit obligations. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of July 31, 2025 and 2024 by \$17,657,149 and \$12,744,123, respectively.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligations. The postretirement benefit obligation is net of projected retiree contributions. The net obligation was 34% and 29% of the total projected accumulated plan benefit obligation before retiree contributions as of July 31, 2025 and 2024, respectively.

The Plan's excess of benefit obligations over net assets at July 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 CBAs. However, the Plan empowers the Plan's Board of Trustees to establish self-payments by eligible retired participants and modify the terms and conditions under which retiree eligibility may be maintained; therefore, the cost to the Plan can be reduced or eliminated prospectively by action of the Plan's Board of Trustees.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 4: Claims Incurred But Not Reported and Medical Reimbursement Accounts

Benefit obligations other than postretirement and accumulated eligibility credits include health claims incurred but not reported and medical reimbursement accounts (MRA).

Claims incurred but not yet reported are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's management. These amounts are paid by the Plan only if claims are submitted and approved for payment.

The MRA is funded solely through employer contributions. The MRA is designed to allow for reimbursement of certain health care expenses and offers credits to maintain eligibility in the Plan. Amounts remaining at the end of the year can generally be carried over to the next year. The Plan is not permitted to refund any part of the balance to the contributing employers and remaining amounts are not portable upon termination of eligibility in the Plan. Access to a member's MRA ends when a member's eligibility for the Plan's medical coverage ends. If a member regains eligibility within three years of the last day of medical coverage, access to the MRA will be reinstated. If the member does not regain eligibility within three years of the last day of medical coverage, any credits remaining in the member's MRA will be permanently forfeited (except in the event of continued coverage of surviving eligible dependents after the death of a member).

Note 5: Fair Value Measurements

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

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

Level 2 Inputs to the valuation methodology include:

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

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

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

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 5: Fair Value Measurements (continued)

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at July 31, 2025 and 2024.

Common collective trust funds: Valued at the net asset value (NAV) of units held. The NAV is used as a practical expedient to estimate fair value. The NAV is based on the fair value of the underlying assets held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the Plan will sell the investment for an amount different than the reported NAV. If the Plan initiates a full redemption, the issuer reserves the right to temporarily delay withdrawal in order to ensure that securities liquidations will be carried out in an orderly manner.

Exchange traded fund: Valued at the daily closing price as reported by the fund. The fund is required to publish its daily NAV and to transact at that price. The exchange traded fund held by the Plan is deemed to be actively traded.

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily NAV and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Money market funds: Valued at cost plus accrued interest, which approximates fair value.

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

| | <u>Level 1</u> | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u> |
|----------------------|----------------------|----------------|----------------|-----------------------|
| Exchange traded fund | \$ 36,289,330 | \$ - | \$ - | \$ 36,289,330 |
| Mutual fund | 37,146,367 | - | - | 37,146,367 |
| Money market funds | <u>21,197,164</u> | <u>-</u> | <u>-</u> | <u>21,197,164</u> |
| Investments at NAV* | \$ <u>73,435,697</u> | \$ <u>-</u> | \$ <u>-</u> | 73,435,697 |
| | | | | <u>67,586,839</u> |
| | | | | \$ <u>162,219,700</u> |

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 5: 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 July 31, 2024:

| | Level 1 | Level 2 | Level 3 | Total |
|---------------------|----------------------|-------------|-------------|--|
| Mutual funds | \$ 73,245,302 | \$ - | \$ - | \$ 73,245,302 |
| Money market funds | <u>11,600,940</u> | <u>-</u> | <u>-</u> | <u>11,600,940</u> |
| Investments at NAV* | <u>\$ 84,846,242</u> | <u>\$ -</u> | <u>\$ -</u> | <u>84,846,242</u> <u>55,807,577</u> |
| | | | | <u>\$ 140,653,819</u> |

*In accordance with the “Fair Value Measurements” topic of the FASB ASC, certain investments that were measured at NAV per share (or its equivalent) have not been classified in the fair value hierarchy. The fair value amounts presented in these tables are intended to permit reconciliation of the fair value hierarchy to the line items presented in the accompanying statements of net assets available for benefits.

The following table summarizes investments measured at fair value based on NAV as a practical expedient as of July 31:

| Investment | Fair Value | | Redemption Frequency (if currently eligible) | Redemption Notice Period |
|--|----------------------|----------------------|---|-----------------------------|
| | 2025 | 2024 | | |
| BlackRock US Equity Market Fund B | \$ 37,915,316 | \$ 33,722,094 | Daily | n/a |
| BlackRock MSCI ACWI EX-US IMI Index Fund B | <u>29,671,523</u> | <u>22,085,483</u> | Daily | n/a |
| | <u>\$ 67,586,839</u> | <u>\$ 55,807,577</u> | | |

Note 6: Staff Pension Plan

The Plan sponsors a non-contributory defined benefit pension plan (the “Staff Pension Plan”) for all eligible employees of the Plan. Benefits under the Staff Pension Plan are based upon years of service and employee compensation. Contributions to the Staff Pension Plan are subject to the ERISA minimum contribution level and the Internal Revenue Service (IRS) maximum contribution limitation. The Plan accounts for benefit obligations of the Staff Pension Plan in accordance with the recognition and disclosure provisions as established by the FASB ASC.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 6: Staff Pension Plan (continued)

Effective January 1, 2010, the Plan terminated the Staff Pension Plan (i.e., a curtailment) subject to the provisions of the Staff Pension Plan and ERISA. Active benefit accruals for all eligible employees were frozen at the termination date. The Plan replaced the Staff Pension Plan with a 401(k) defined contribution plan for all eligible employees effective January 1, 2010 (Note 7). Effective January 1, 2024, the Staff Pension Plan was reinstated to allow for employees to earn benefit accruals.

The reconciliation of the change in the Staff Pension Plan benefit obligation, fair value of assets, and funded status are as follows as of and for the year ended July 31:

| | 2025 | 2024 |
|---|----------------------|----------------------|
| <u>Change in fair value of assets:</u> | | |
| Fair value of assets, beginning of year | \$ 12,377,344 | \$ 11,651,920 |
| Actual return on plan assets | 1,247,145 | 1,365,973 |
| Benefits paid | (618,733) | (640,549) |
| Fair value of assets, end of year | \$ <u>13,005,756</u> | \$ <u>12,377,344</u> |
| <u>Change in benefit obligation:</u> | | |
| Benefit obligation, beginning of year | \$ 9,989,988 | \$ 10,598,808 |
| Service cost | 356,528 | - |
| Interest cost | 513,664 | 511,846 |
| Plan amendments | - | 203,645 |
| Actuarial gain | (143,119) | (683,762) |
| Benefits paid | (618,733) | (640,549) |
| Benefit obligation, end of year | \$ <u>10,098,328</u> | \$ <u>9,989,988</u> |
| Funded status at end of year | \$ <u>2,907,428</u> | \$ <u>2,387,356</u> |

The actuarial gain for the years ended July 31, 2025 and 2024 related to an increase in the discount rate, demographic experience, and changes to the mortality and retirement assumptions.

The following table provides the amounts recognized in the accompanying statements of net assets available for benefits as of July 31:

| | 2025 | 2024 |
|--|---------------------|---------------------|
| Benefit asset | \$ 2,907,428 | \$ 2,387,356 |
| Less: allocation of asset to Other Funds | (1,434,041) | (1,186,645) |
| | \$ <u>1,473,387</u> | \$ <u>1,200,711</u> |

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 6: Staff Pension Plan (continued)

The components of net periodic benefit cost and total plan expenses are as follows for the years ended July 31:

| | 2025 | 2024 |
|--|------------------|------------------|
| Service cost | \$ 356,528 | \$ - |
| Interest cost | 513,663 | 511,846 |
| Expected return on assets | (766,328) | (757,852) |
| New prior service cost | - | 203,645 |
| Plan net gain | (623,936) | (1,291,883) |
| Net period benefit cost | (520,073) | (1,334,244) |
| Other costs (advisor, custodian, and actuary fees) | 40,732 | 40,159 |
| Total staff pension plan gain | (479,341) | (1,294,085) |
| Less: allocation to Other Funds | 227,306 | 655,900 |
| Net gain on staff pension plan | \$ (252,035) | \$ (638,185) |

The following assumptions were used in the calculation of the actuarial present value of benefit obligations at July 31:

| | 2025 | 2024 |
|-------------------------------|-------|-------|
| Discount rate | 5.50% | 5.25% |
| Rate of compensation increase | 3.00% | 3.00% |

The following assumptions were used to determine the net benefit costs for the years ended July 31:

| | 2025 | 2024 |
|--|-------|-------|
| Discount rate | 5.25% | 5.00% |
| Rate of compensation increase | 3.00% | N/A |
| Expected long-term rate of return on plan assets | 6.25% | 6.25% |

The investment objective of the Staff Pension Plan is to approximate the return of a weighted benchmark of appropriate market indices based on the Staff Pension Plan's asset allocation policy. The policy allocations are as follows:

| | Allocation |
|-----------------|------------|
| Cash | * |
| Fixed income | 40% |
| U.S. equity | 35% |
| Non-U.S. equity | 25% |

*Cash reserves are based on the levels needed to meet liquidity needs. Cash reserves are included in the fixed income portion of the asset allocation policy

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 6: Staff Pension Plan (continued)

The Staff Pension Plan’s assets are managed by institutional investment managers who have been selected based upon their respective investment discipline and historical performance. The asset allocation is the primary determinant of investment risk exposure, return levels, and current income generation. The Plan’s Board of Trustees have determined the policy asset allocation for the Staff Pension Plan based upon a study of both historical and projected rates of return for various asset classes separately and in various combinations over multi-year holding periods. Target allocation ranges are guidelines, not limitations, and occasionally Staff Pension Plan advisors will recommend allocations above or below a target range.

The following table sets forth by level, within the fair value hierarchy (Note 5), the Staff Pension Plan’s assets at fair value as of July 31, 2025:

| | <u>Level 1</u> | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u> |
|---------------------|---------------------|----------------|----------------|----------------------|
| Mutual funds | \$ 6,044,425 | \$ - | \$ - | \$ 6,044,425 |
| Money market funds | <u>196,669</u> | <u>-</u> | <u>-</u> | <u>196,669</u> |
| Investments at NAV* | <u>\$ 6,241,094</u> | <u>\$ -</u> | <u>\$ -</u> | 6,241,094 |
| | | | | <u>6,764,662</u> |
| | | | | <u>\$ 13,005,756</u> |

The following table sets forth by level, within the fair value hierarchy (Note 5), the Staff Pension Plan’s assets at fair value as of July 31, 2024:

| | <u>Level 1</u> | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u> |
|---------------------|---------------------|----------------|----------------|----------------------|
| Mutual funds | \$ 5,760,220 | \$ - | \$ - | \$ 5,760,220 |
| Money market funds | <u>205,854</u> | <u>-</u> | <u>-</u> | <u>205,854</u> |
| Investments at NAV* | <u>\$ 5,966,074</u> | <u>\$ -</u> | <u>\$ -</u> | 5,966,074 |
| | | | | <u>6,411,270</u> |
| | | | | <u>\$ 12,377,344</u> |

*In accordance with the “Fair Value Measurements” topic of the FASB ASC, certain investments that were measured at NAV per share (or its equivalent) have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to total fair value of Staff Pension Plan assets at July 31, 2025 and 2024, respectively.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 6: Staff Pension Plan (continued)

The following table summarizes investments measured at fair value based on NAV as a practical expedient as of July 31:

| Investment | Fair Value | | Redemption Frequency (if currently eligible) | Redemption Notice Period |
|---|---------------------|---------------------|---|-----------------------------|
| | 2025 | 2024 | | |
| BlackRock US Equity Market Fund | \$ 5,094,189 | \$ 4,826,711 | Daily | n/a |
| BlackRock MSCI ACWI EX-US IMI Index Fund | <u>1,670,473</u> | <u>1,584,559</u> | Daily | n/a |
| | <u>\$ 6,764,662</u> | <u>\$ 6,411,270</u> | | |

The Plan does not expect to make a contribution to the Staff Pension Plan for the fiscal year ending July 31, 2026. The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending July 31:

| | |
|-------------------|------------|
| 2026 | \$ 673,395 |
| 2027 | 663,365 |
| 2028 | 733,630 |
| 2029 | 773,685 |
| 2030 | 790,885 |
| 2031 through 2035 | 3,967,158 |

Note 7: Defined Contribution Plan

Employees of the Plan can participate in a 401(k) defined contribution plan. The Plan makes employer matching contributions and discretionary employer contributions to participants' accounts. The following table provides the amounts recognized in the accompanying statements of changes in net assets available for benefits (within operating expenses) for the years ended July 31:

| | <u>2025</u> | <u>2024</u> |
|---|------------------|------------------|
| Staff 401(k) plan expenses | \$ 192,378 | \$ 154,018 |
| Less: allocation of expenses to Other Funds | <u>(94,887)</u> | <u>(76,555)</u> |
| | <u>\$ 97,491</u> | <u>\$ 77,463</u> |

Note 8: Reciprocity Agreements

The Plan has entered into reciprocity agreements with certain health and welfare plans administered by other unions. In accordance with these agreements, the Plan is required to remit funds received and is entitled to receive funds from participating employers on behalf of temporary employees to and from the employees' participating unions.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 8: Reciprocity Agreements (continued)

For the years ended July 31, 2025 and 2024, the Plan remitted \$6,059,342 and \$4,127,057, respectively, of reciprocal payments in accordance with these agreements with the participating unions. Payments made to other plans for reciprocal contributions collected on behalf of those plans are included in employers' contributions in the accompanying statements of changes in net assets available for benefits as they do not represent an expense of the Plan.

Reciprocal payments received are included in employers' contributions in the accompanying statements of changes in net assets available for benefits. No allowance for credit losses as of July 31, 2025 and 2024 was necessary for reciprocal payments due to the Plan.

Note 9: Tax Status

The Plan received an exemption letter from the IRS stating that the VEBA trust established under the Plan was in compliance with the applicable requirements of the provisions of Section 501(c)(9) of the Internal Revenue Code (IRC). No federal or state income taxes have been recorded for the years ended July 31, 2025 and 2024 for unrelated business taxable income. The Plan and the trust are required to operate in conformity with the IRC to maintain the tax-exempt status of the trust. The Plan Administrator believes that the Plan is being operated in compliance with the applicable requirements of the IRC and, therefore, believes that the related trust is tax-exempt as of the financial statement date.

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

Note 10: Priorities Upon Termination of the Plan

Although the Plan's Board of Trustees has not expressed intent to discontinue the Plan, they may do so at any time subject to the provisions of ERISA and the terms of the CBAs. In the event of termination of the Plan, the assets of the Plan would continue to be used to pay reasonable administrative expenses and to distribute and apply remaining surplus as the Plan's Board of Trustees so determine, until no assets remain.

Note 11: Party in Interest and Related Party Transactions

The Plan has a cost-sharing agreement with The Ohio Operating Engineers Pension Plan (the "Pension Plan"), Ohio Operating Engineers Apprenticeship and Training Fund, and Ohio Operating Engineers Education and Safety Fund (collectively, the "Other Funds") whereby certain operating expenses, including staff pension and 401(k) plan costs, are shared. For the years ended July 31, 2025 and 2024, \$1,917,946 and \$1,575,592, respectively, were allocated to the Other Funds (excluding Staff Pension Plan expense) in accordance with the cost-sharing agreement. The allocation of the net gain on the Staff Pension Plan of \$227,306 and \$655,900 for the years ended July 31, 2025 and 2024, respectively, were allocated to the Other Funds.

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 11: Party in Interest and Related Party Transactions (continued)

During the years ended July 31, 2025 and 2024, real estate taxes and depreciation of capitalized property and equipment of \$231,377 and \$221,113, respectively, incurred by the Pension Plan, were allocated to the Plan.

Due from the Other Funds related to the allocation of shared expenses, net of amounts due by the Plan to the Pension Plan for allocated real estate taxes and depreciation, was \$1,301,709 and \$976,766 at July 31, 2025 and 2024, respectively. At July 31, 2025 and 2024, \$934,746 and \$1,936,924, respectively, was due from the Pension Plan related to employer contributions received and processed, but not yet remitted to the Plan.

Certain Plan investments are held by custodians that also serve as the money manager for the investments. Therefore, these investments and transactions in these investments qualify as party in interest transactions, which are exempt from the prohibited transaction rules of ERISA. 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 12: 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 changes in the values of investment securities will occur in the near term and that such change 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 13: Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of July 31:

| | 2025 | 2024 |
|--|-----------------|-----------------|
| Net assets available for benefits per the financial statements | \$ 185,308,475 | \$ 161,120,385 |
| Claims incurred but not reported | (22,705,400) | (16,179,800) |
| Accumulated eligibility credits | (158,034,700) | (136,270,200) |
| Medical reimbursement accounts | (53,784,121) | (51,120,378) |
| Net assets available for benefits per Form 5500 | \$ (49,215,746) | \$ (42,449,993) |

Ohio Operating Engineers Health and Welfare Plan

Notes to Financial Statements

July 31, 2025 and 2024

Note 13: Reconciliation of Financial Statements to Form 5500 (continued)

The following is a reconciliation of the change in the net assets available for benefits per the financial statements to the Form 5500 for the years ended July 31:

| | 2025 | 2024 |
|---|----------------|-----------------|
| Net increase per the financial statements | \$ 24,188,090 | \$ 8,156,086 |
| Add: claims incurred but not reported, end of prior year | 16,179,800 | 12,930,000 |
| Add: accumulated eligibility credits, end of prior year | 136,270,200 | 118,287,700 |
| Add: medical reimbursement accounts, end of prior year | 51,120,378 | 47,208,709 |
| Less: claims incurred but not reported, end of current year | (22,705,400) | (16,179,800) |
| Less: accumulated eligibility credits, end of current year | (158,034,700) | (136,270,200) |
| Less: medical reimbursement accounts, end of current year | (53,784,121) | (51,120,378) |
| Net decrease per the Form 5500 | \$ (6,765,753) | \$ (16,987,883) |

Claims incurred but not reported and accumulated eligibility credits are not considered liabilities under GAAP; therefore, these amounts are not presented as liabilities or claims and insurance premiums paid for health benefits in the accompanying financial statements, but are recorded on the Form 5500 as a liability.

Ohio Operating Engineers Health and Welfare Plan

Supplemental Schedule Statements of Operating Expenses

For the years ended July 31, 2025 and 2024

| | 2025 | 2024 |
|-----------------------------------|--------------|--------------|
| Salaries and wages | \$ 1,059,544 | \$ 828,377 |
| Data processing | 265,421 | 241,035 |
| Utilities | 31,756 | 41,687 |
| Telephone | 14,430 | 10,969 |
| Postage | 119,300 | 66,889 |
| Building maintenance | 52,945 | 39,592 |
| Other office supplies and expense | 68,210 | 37,207 |
| Payroll taxes | 79,784 | 63,938 |
| Real estate taxes | 59,718 | 56,085 |
| Insurance | 9,963 | 10,052 |
| Staff 401(k) plan expenses | 97,491 | 77,463 |
| Staff education and safety | 2,411 | 2,364 |
| Staff group insurance | 147,906 | 140,552 |
| Depreciation | 171,659 | 165,028 |
| Trustees' travel and expense | 1,737 | 8,015 |
| Equipment maintenance and repair | 18,116 | 20,562 |
| Automobile expenses | 7,143 | 7,797 |
| Legal fees | 131,861 | 141,211 |
| Accounting and auditing fees | 63,370 | 60,655 |
| Bank service charges | 17,851 | 16,992 |
| Staff travel and expense | 5,471 | 7,237 |
| Administrator's expense | 973 | 1,451 |
| Payroll processing fees | 3,852 | 3,525 |
| Other professional fees | 47,288 | 45,750 |
| Bad debt expense | 200 | 2,974 |
| Dues and subscriptions | 3,057 | 2,514 |
| Miscellaneous | 5,478 | 1,840 |
| | \$ 2,486,935 | \$ 2,101,761 |

Ohio Operating Engineers Health and Welfare Plan

Supplemental Schedule Statement of Investments and Investment Income by Investment Manager

As of and for the year ended July 31, 2025

| | <u>JPMorgan</u> | <u>Loomis Sayles</u> | <u>Metropolitan West</u> | <u>TCW Group</u> | <u>Blackrock</u> | <u>Total</u> |
|---|----------------------|--------------------------|------------------------------|-----------------------|----------------------|-----------------------|
| Investments at fair value, as of July 31, 2025: | | | | | | |
| Common collective trust funds | \$ - | \$ - | \$ - | \$ - | \$ 67,586,839 | \$ 67,586,839 |
| Exchange traded fund | - | - | - | 36,289,330 | - | 36,289,330 |
| Mutual fund | - | 37,146,367 | - | - | - | 37,146,367 |
| Money market funds | <u>21,188,746</u> | <u>-</u> | <u>-</u> | <u>-</u> | <u>8,418</u> | <u>21,197,164</u> |
| | <u>\$ 21,188,746</u> | <u>\$ 37,146,367</u> | <u>\$ -</u> | <u>\$ 36,289,330</u> | <u>\$ 67,595,257</u> | <u>\$ 162,219,700</u> |
| Investment income, for the year ended July 31, 2025: | | | | | | |
| Interest | \$ 755,253 | \$ - | \$ - | \$ - | \$ 5,990 | \$ 761,243 |
| Dividends | - | 1,557,701 | 1,188,761 | 124,162 | - | 2,870,624 |
| Net appreciation (depreciation) in fair value of investments | <u>-</u> | <u>367,108</u> | <u>2,775,885</u> | <u>(2,395,800)</u> | <u>8,779,336</u> | <u>9,526,529</u> |
| | <u>\$ 755,253</u> | <u>\$ 1,924,809</u> | <u>\$ 3,964,646</u> | <u>\$ (2,271,638)</u> | <u>\$ 8,785,326</u> | <u>\$ 13,158,396</u> |

| | | |
|---|---|---|
| Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500. | OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> This Form is Open to Public Inspection |
|---|---|---|

| | |
|--|--|
| Part I Annual Report Identification Information | |
| For calendar plan year 2024 or fiscal plan year beginning <u>08/01/2024</u> and ending <u>07/31/2025</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) |
| B This return/report is: | |
| C If the plan is a collectively-bargained plan, check here | <input checked="" type="checkbox"/> |
| D Check box if filing under: | <input 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 OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN 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) OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN C/O BOARD OF TRUSTEES 1180 DUBLIN ROAD VS COLUMBUS OH 43215-7003 | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">1b Three-digit plan number (PN) ▶</td> <td style="width:50%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">03/11/1960</td> </tr> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">31-4446857</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">(614) 488-0708</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">237990</td> </tr> </table> | 1b Three-digit plan number (PN) ▶ | 501 | 1c Effective date of plan | 03/11/1960 | 2b Employer Identification Number (EIN) | 31-4446857 | 2c Plan Sponsor's telephone number | (614) 488-0708 | 2d Business code (see instructions) | 237990 |
| 1b Three-digit plan number (PN) ▶ | 501 | | | | | | | | | | |
| 1c Effective date of plan | 03/11/1960 | | | | | | | | | | |
| 2b Employer Identification Number (EIN) | 31-4446857 | | | | | | | | | | |
| 2c Plan Sponsor's telephone number | (614) 488-0708 | | | | | | | | | | |
| 2d Business code (see instructions) | 237990 | | | | | | | | | | |

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 | <i>x Carol A. Wilson</i> | <i>x 2/18/26</i> | <i>x Carol A. Wilson</i> |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

| | | |
|---|---|---|
| Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation | Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500. | OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> This Form is Open to Public Inspection |
|---|---|---|

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning **08/01/2024** and ending **07/31/2025**

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

B This return/report is: a single-employer plan a DFE (specify) _____

the first return/report the final return/report

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

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

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

special extension (enter description)

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

Part II Basic Plan Information --- enter all requested information

| | |
|---|--|
| 1a Name of plan OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN | 1b Three-digit plan number (PN) ▶ 501 1c Effective date of plan 03/11/1960 |
| 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) OHIO OPERATING ENGINEERS HEALTH AND WELFARE PLAN C/O BOARD OF TRUSTEES 1180 DUBLIN ROAD US COLUMBUS OH 43215-7003 | 2b Employer Identification Number (EIN) 31-4446857 2c Plan Sponsor's telephone number (614) 488-0708 2d Business code (see instructions) 237990 |

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 | | | |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> 2/20/2026 | <input checked="" type="checkbox"/> Robert L. Hughes |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

| | | |
|--|--|--|
| 3a Plan administrator's name and address <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 and 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 | 13,389 |
|---|----------|--------|

| | | |
|--|--------------|--------|
| 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) | 9,887 |
| a(2) Total number of active participants at the end of the plan year | 6a(2) | 10,314 |
| b Retired or separated participants receiving benefits | 6b | 3,358 |
| c Other retired or separated participants entitled to future benefits | 6c | |
| d Subtotal. Add lines 6a(2), 6b, and 6c | 6d | 13,672 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e | |
| f Total. Add lines 6d and 6e | 6f | |
| g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | 6g(1) | |
| g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g(2) | |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h | |

| | | |
|--|----------|-------|
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) . | 7 | 1,096 |
|--|----------|-------|

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 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 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) **R** (Retirement Plan Information)

(2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(4) **DCG** (Individual Plan Information) - Number Attached _____

(5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

(1) **H** (Financial Information)

(2) **I** (Financial Information - Small Plan)

(3) **A** (Insurance Information) - Number Attached _____

(4) **C** (Service Provider Information)

(5) **D** (DFE/Participating Plan Information)

(6) **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

**Ohio Operating Engineers
Health and Welfare Plan**

ERISA-required Supplemental Schedule

EIN: 31-4446857

Plan No.: 501

July 31, 2025

Schedule H, Line 4i – Schedule of Assets (Held at End of Year)

| (a) | (b) Identity of issue, borrower, lessor, or similar party | (c) Description of investment including maturity date, rate of interest collateral, par, or maturity value | (d) Cost | (e) Current value |
|-----|--|---|-----------------------|-----------------------|
| | Common collective trust funds: | | | |
| * | BlackRock | MSCI ACWI EX-US IMI Index Fund B, 1,224,212 units | \$ 19,533,611 | \$ 29,671,523 |
| * | BlackRock | US Equity Market Fund B, 120,614 units | 12,113,474 | 37,915,316 |
| | | | <u>31,647,085</u> | <u>67,586,839</u> |
| | Exchange traded fund: | | | |
| | TCW Group | Core Plus Bond ETF, 955,085 shares | 38,685,161 | 36,289,330 |
| | | | <u>38,685,161</u> | <u>36,289,330</u> |
| | Mutual fund: | | | |
| | Loomis Sayles | Intermediate Duration Bond Fund, 3,881,543 shares | 37,999,623 | 37,146,367 |
| | | | <u>37,999,623</u> | <u>37,146,367</u> |
| | Money market funds: | | | |
| * | BlackRock | Money Market Fund B, 8,418 units | 8,418 | 8,418 |
| * | JPMorgan | US Government Money Market Fund Capital Shares, 21,188,746 shares | 21,188,746 | 21,188,746 |
| | | | <u>21,197,164</u> | <u>21,197,164</u> |
| | | | <u>\$ 129,529,033</u> | <u>\$ 162,219,700</u> |

*Indicates a party in interest

**Ohio Operating Engineers
Health and Welfare Plan**

ERISA-required Supplemental Schedule

EIN: 31-4446857

Plan No.: 501

For the year ended July 31, 2025

Schedule H, Line 4j – Schedule of Reportable Transactions

| (a) Identity of party involved | (b) Description of asset (include interest rate and maturity in case of loan) | (c) Purchase price | (d) Selling price | (e) Lease rental | (f) Expense incurred with transaction | (g) Cost of asset | (h) Current value of asset on transaction date | (i) Net gain or (loss) |
|--------------------------------|---|--------------------|-------------------|------------------|---------------------------------------|-------------------|--|------------------------|
| <u>Single transactions:</u> | | | | | | | | |
| JPMorgan | US Government Money Market Fund Capital Shares | \$ 11,746,057 | \$ - | \$ - | \$ - | \$ 11,746,057 | \$ 11,746,057 | \$ - |
| <u>Series transactions:</u> | | | | | | | | |
| JPMorgan | US Government Money Market Fund Capital Shares | | | | | | | |
| | 139 purchases | \$ 164,494,614 | \$ - | \$ - | \$ - | \$ 164,494,614 | \$ 164,494,614 | \$ - |
| | 91 sales | - | 154,904,455 | - | - | 154,904,455 | 154,904,455 | - |