Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2024** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

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

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

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 07/13/1950

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)
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN

660 N. INDUSTRIAL DRIVE
SUITE 100
ELMHURST, IL 60126

2b Employer Identification Number (EIN) 36-2150067

2c Plan Sponsor's telephone number 630-617-8600

2d Business code (see instructions) 238100

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.	03/12/2026	MICHAEL VOLPENTESTA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	03/10/2026	RICHARD LAUBER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	2278
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)**	1465
a(2) Total number of active participants at the end of the plan year	**6a(2)**	1360
b Retired or separated participants receiving benefits	**6b**	806
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2166
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**	182

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

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

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

A Name of plan	**B** Three-digit plan number (PN) ▶
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN	36-2150067

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

1 Coverage Information:

(a) Name of insurance carrier

THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
13-1423090	69744	SL10172	1479	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
5742	0

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

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

THE SEGAL COMPANY
333 WEST 34TH STREET
NEW YORK, NY 10001

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
5742			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	729592
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

A Name of plan	**B** Three-digit plan number (PN) ▶
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN	36-2150067

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

1 Coverage Information:

(a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
01-0278678	62235	417713	1349	06/01/2024	05/31/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	104958
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

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

A Name of plan	**B** Three-digit plan number (PN) ▶
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN	36-2150067

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

1 Coverage Information:

(a) Name of insurance carrier

HUMANA INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
39-1263473	73288	329917	1028	06/01/2024	05/31/2025

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
240308	0

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

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

THE SEGAL COMPANY MIDWEST
7701 FRANCE AVE. S, STE 225
EDINA, MN 55435

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
180968			3

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

LABOR-FIRST LLC
1000 MIDLANTIC DR, STE 100
MOUNT LAUREL, NJ 08054

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
59340			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	1472537
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN

D Employer Identification Number (EIN)
36-2150067

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

HARDING LOEVNER
400 CROSSING BLVD., 4TH FLOOR
BRIDGEWATER, NJ 08807

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

FIDELITY MGMT & RES COMPANY LLC
245 SUMMER STREET
BOSTON, MA 02210

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

ROBERT W. BAIRD & CO.
615 E. MICHIGAN STREET
MILWAUKEE, WI 53202

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

THE VANGUARD GROUP

23-1945930

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

GOLDMAN SACHS ASSET MGMT

71 S. WACKER DRIVE, STE 500
CHICAGO, IL 60606

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

T. ROWE PRICE ASSOCIATES, INC.

100 EAST PRATT STREET
BALTIMORE, MD 21202

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

CAPITAL RESEARCH AND MANAGEMENT

333 S. HOPE STREET, 53RD FLOOR
LOS ANGELES, CA 90071

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

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

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

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

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

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

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

BLUECROSS BLUESHIELD OF IL

36-1236610

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 73	NONE	720556	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

(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 16 55	NONE	66469	Yes [X] No [ ]	Yes [ ] No [X]	280507	Yes [ ] No [X]

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

NATIONAL INVESTMENT SERVICES

84-3937993

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	190885	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

WENDY SKOUMAL

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	155145	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ROSE-ANN DOYIAKOS

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	155102	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MONIKA KOLPAK

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	115451	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

CAROLYN COOK

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	106229	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DOUG JOHNSTON

36-2150067

(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?
20	EMPLOYEE/TRUSTEE	99173	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NICK MARINOPOULOS

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	99173	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

LEGACY PROFESSIONALS LLP

32-0043599

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 15	NONE	96621	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KARELY DIAZ

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	95121	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BOZENA DENIGRIS

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	89665	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

WASHINGTON CAPITAL MGMT

1200 SIXTH AVE., STE 700
SEATTLE, WA 98101

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	84109	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MELODY NEYLAND

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 30	EMPLOYEE	82080	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASHER, GITTLER & D'ALBA, LTD.

36-2786883

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	72258	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

VISION SERVICE PLAN OF ILLINOIS

20-0891619

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	60411	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 16 49 55	NONE	57246	Yes ☒ No ☐	Yes ☐ No ☒	549	Yes ☐ No ☒

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

MONIKA FILAR

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	50839	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

MELISSA FURTYO

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	50003	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DONNA REYES

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	47685	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MIRIAM PAGAN

36-2150067

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	45123	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

VALENZ CARE

81-5149270

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	43116	Yes ☐ No ☐	Yes ☐ No ☐	0	Yes ☐ No ☐

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

OPTUM RX

33-0441200

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	39416	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LANER MUCHIN, LTD.

36-3088463

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	36050	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

STRATEGIC CAPITAL INV ADVISORS

36-4268991

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	NONE	32050	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LASALLE CONSULTING PARTNERS, INC.

36-4030449

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	28218	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALLONE HEALTH EAP

36-3867645

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	25736	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

FAIR HEALTH, INC.

90-0524293

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 49	NONE	15869	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DENTAL NETWORK OF AMERICA

36-3339483

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 49	NONE	13534	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GREEN LIGHT COST MGMNT

45-5248276

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	13165	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SOMMERS & FAHRENBACH

36-1796440

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36	NONE	10786	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

THE NORTHERN TRUST COMPANY

36-1561860

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18	NONE	10577	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DOWD, BLOCH, BENNETT & CERVONE

36-3371377

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	10481	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SEGAL SELECT INSURANCE SERVICES

46-0619194

(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?
22	NONE	9509	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MIDWEST INSTITUTIONAL TRUST CO

93-1799133

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 31 49 51 62	NONE	9192	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☐

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

ABSOLUTE SOLUTIONS

27-3584158

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	5276	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

CHANGE HEALTHCARE SOLUTIONS

20-5716594

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	5211	Yes ☐ No ☐	Yes ☐ No ☐	0	Yes ☐ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
THE SEGAL COMPANY	11 16 55	280507

(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.
HUMANA INSURANCE COMPANY 39-1263473	INSURANCE CONTRACT COMMISSIONS

(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
CHANGE HEALTHCARE SOLUTIONS 20-5716594	49	DID NOT RESPOND TO THE PLAN'S MULTIPLE REQUESTS FOR INFORMATION REGARDING INDIRECT COMPENSATION RECEIVED.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
VALENZ CARE 81-5149270	49	DID NOT RESPOND TO THE PLAN'S MULTIPLE REQUESTS FOR INFORMATION REGARDING INDIRECT COMPENSATION RECEIVED.

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

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

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

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

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

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

A Name of plan
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN

D Employer Identification Number (EIN)
36-2150067

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: NIS CORE FIXED INCOME QP FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN 82-4028492-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 15814212

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS HIGH YIELD QP FUND

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN 82-4051841-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2314889

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS TOT. ABSOL. RETURN QP FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN 82-4069919-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 4304138

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS INTER. FIXED INC. QP FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN 82-4087168-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 25531964

a Name of MTIA, CCT, PSA, or 103-12 IE: REAL ASSET INCOME FUND, LLC

b Name of sponsor of entity listed in (a): WASHINGTON CAPITAL MANAGEMENT, INC

c EIN-PN 86-3454983-001 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 16681376

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)

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
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a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN

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

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

A Name of plan
ADMINISTRATIVE DISTRICT COUNCIL 1 WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF ADMINISTRATIVE DISTRICT COUNCIL NO. 1 WELFARE FUN

D Employer Identification Number (EIN)
36-2150067

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	1171568	631062
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3021106	2876156
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	2705639	2722331
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	167961	171818
(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)	50062679	47965203
(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)	15576556	16681376
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	75259928	78035956
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	72774	73876
f Total assets (add all amounts in lines 1a through 1e)	1f	148038211	149157778
Liabilities			
g Benefit claims payable	1g	4297071	5610915
h Operating payables	1h	194184	315671
i Acquisition indebtedness	1i		
j Other liabilities	1j	33314	24548
k Total liabilities (add all amounts in lines 1g through1j)	1k	4524569	5951134
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	143513642	143206644

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)	23501214	
(B) Participants	2a(1)(B)	874560	
(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)		24375774
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	8785	
(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)		8785
(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)	1661519	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		1661519
(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)		3402523
(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)		1104820
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		6614508
c Other income	2c		4975009
d Total income. Add all **income** amounts in column (b) and enter total	2d		42142938
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	35768917	
(2) To insurance carriers for the provision of benefits	2e(2)	2198119	
(3) Other	2e(3)	930219	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		38897255
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)	2156524	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	36971	
(4) IQPA audit fees	2i(4)	59650	
(5) Investment advisory and investment management fees	2i(5)	316236	
(6) Bank or trust company trustee/custodial fees	2i(6)	10577	
(7) Actuarial fees	2i(7)	66469	
(8) Legal fees	2i(8)	119182	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	16108	
(11) Other expenses	2i(11)	770964	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		3552681
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		42449936
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-306998
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

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

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: LEGACY PROFESSIONALS LLP **(2)** EIN: 32-0043599

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

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

Part IV Compliance Questions

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

During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		3000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

Administrative District Council 1 Welfare Fund

Financial Statements

May 31, 2025

Administrative District Council 1 Welfare Fund

Financial Statements with Supplementary Information

May 31, 2025 and 2024

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Supplementary Information	
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Schedule H, Line 4j - Schedule of Reportable Transactions	2

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

Report of Independent Auditors

To the Participants and Trustees of
Administrative District Council 1 Welfare Fund

Opinion

We have audited the financial statements of Administrative District Council 1 Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of May 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of Administrative District Council 1 Welfare Fund as of May 31, 2025 and 2024, and the changes in its net assets available for benefits and benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

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

In performing an audit in accordance with GAAS, we:

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

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

Legacy Professionals LLP

Westchester, Illinois

October 30, 2025

Administrative District Council 1 Welfare Fund

Statements of Net Assets Available for Benefits

May 31, 2025 and 2024

	2025	2024
Assets		
Investments - at fair value		
Mutual funds	$ 78,035,956	$ 75,259,928
Commingled investment funds	64,646,579	65,639,235
Money market fund	171,818	167,961
Total investments	142,854,353	141,067,124
Receivables		
Contractor contributions	2,876,156	3,021,106
Contractor contributions due from lockbox account	1,399,892	1,309,782
Prescription drug rebates	948,792	1,132,532
Contribution processing fees	4,381	4,241
Subrogation settlements	42,670	137,318
Due from related organizations	181,463	96,578
Total receivables	5,453,354	5,701,557
Other assets		
Property and equipment - net	73,876	72,774
Prepaid expenses	145,133	25,188
Cash	631,062	1,171,568
Total other assets	850,071	1,269,530
Total assets	149,157,778	148,038,211
Liabilities and Net Assets		
Liabilities		
Accounts payable and accrued expenses	228,372	194,184
Contributions paid in advance	24,548	33,314
Due to related organizations	87,299	-
Total liabilities	340,219	227,498
Net assets available for benefits	$ 148,817,559	$ 147,810,713

See accompanying notes to financial statements.

Administrative District Council 1 Welfare Fund

Statements of Changes in Net Assets Available for Benefits

Years Ended May 31, 2025 and 2024

	2025	2024
Additions		
Investment income		
Net appreciation in fair value of investments	$ 11,121,851	$ 14,904,309
Interest and dividends	1,670,304	1,511,008
	12,792,155	16,415,317
Less investment expenses	(316,236)	(279,754)
Investment income - net	12,475,919	16,135,563
Contractor contributions	23,501,214	26,099,053
Retiree contributions	659,557	695,087
Prescription drug rebates	2,885,216	2,828,192
Stop-loss reimbursements	291,197	134,319
Participant contributions	117,044	87,777
COBRA premiums and subsidies	97,959	56,715
JAB and other collection-related income	76,973	178,516
Medicare Part D subsidies	13,287	23,005
Contribution processing fees	63,652	71,124
Subrogation settlements	116,198	162,983
Transitional reinsurance fee refund	140,091	-
Miscellaneous income	97,430	30,180
Total additions	40,535,737	46,502,514
Deductions		
Cost of benefits		
Health, dental and vision	24,995,507	25,064,954
Prescription drug	8,791,561	7,548,507
Medicare Advantage Plan (MAP)	1,369,950	679,676
Health Reimbursement Arrangement (HRA)	618,005	565,935
Death	50,000	25,000
Group insurance premiums	828,169	824,090
PPO and administrative fees	839,128	845,219
Claims-related expenses	91,091	91,252
Total cost of benefits	37,583,411	35,644,633
Fees mandated by ACA	14,164	13,520
Administrative expenses - net	1,931,316	2,003,406
Total deductions	39,528,891	37,661,559
Net increase	1,006,846	8,840,955
Net assets available for benefits		
Beginning of year	147,810,713	138,969,758
End of year	$ 148,817,559	$ 147,810,713

See accompanying notes to financial statements.

Administrative District Council 1 Welfare Fund

Statements of Benefit Obligations

May 31, 2025 and 2024

	2025	2024
Amounts currently payable		
Claims payable and claims incurred but not reported	$ 5,610,915	$ 4,297,071
Other obligations for current benefit		
coverage, at estimated amounts		
Participants' continuing eligibility	12,329,000	12,192,000
Postretirement benefit obligations		
Current retirees, beneficiaries and dependents	46,248,336	28,896,851
Other participants fully eligible for benefits	39,532,283	22,354,902
Other participants not yet fully eligible for benefits	28,747,216	18,167,455
Total postretirement benefit obligations	114,527,835	69,419,208
Total benefit obligations	$ 132,467,750	$ 85,908,279

See accompanying notes to financial statements.

Administrative District Council 1 Welfare Fund

Statements of Changes in Benefit Obligations

Years Ended May 31, 2025 and 2024

	2025	2024
Amounts currently payable		
Balance at beginning of year	$ 4,297,071	$ 3,812,791
Increase during the year attributable to changes in		
Claims payable and claims incurred but not reported	1,313,844	484,280
Balance at end of year	5,610,915	4,297,071
Other obligations for current benefit		
coverage, at estimated amounts		
Balance at beginning of year	12,192,000	11,378,000
Increase during the year attributable to changes in		
Participants' continuing eligibility	137,000	814,000
Balance at end of year	12,329,000	12,192,000
Postretirement benefit obligations		
Balance at beginning of year	69,419,208	105,159,361
Increase (decrease) during the year attributable to		
Actuarial experience loss	-	3,841,883
Changes in actuarial assumptions	40,185,958	(5,590,234)
Benefits earned, net of benefits paid	526,785	1,710,393
Plan amendments	4,395,884	(35,702,195)
Balance at end of year	114,527,835	69,419,208
Total benefit obligations	$ 132,467,750	$ 85,908,279

See accompanying notes to financial statements.

Administrative District Council 1 Welfare Fund

Notes to Financial Statements

May 31, 2025 and 2024

Note 1. Summary of Significant Accounting Policies

Method of Accounting - The accompanying financial statements of Administrative District Council 1 Welfare Fund (the Plan) have been prepared using the accrual basis of accounting.

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

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

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

Contributions Receivable - Contractor contributions due and not received by year end are recorded as contractor contributions receivable. Contractor contributions owed as a result of payroll compliance audits are recorded as income upon settlement with the contractor. An allowance for uncollectible accounts is considered unnecessary and is not provided.

Property and Equipment - Property and equipment are recorded at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed by the straight-line method over the estimated useful lives of the related assets, which range from three to ten years.

Depreciation expense was $24,646 and $23,942 for the years ended May 31, 2025 and 2024, respectively.

Revenue Recognition - Revenue derived from contractor contributions is recognized in the period in which covered work is performed, based on the number of hours worked in covered employment and the contribution rate currently in effect, as set forth in the applicable collective bargaining agreement. Contractors are required to remit contributions on a monthly basis. The Plan carries out its purpose described in Note 2 primarily in the greater Chicagoland area.

Note 1. Summary of Significant Accounting Policies (continued)

Reciprocal Contributions - The Plan is signatory to reciprocity agreements with various other multiemployer welfare plans for its participants who perform work outside the geographic jurisdiction of the local unions. Participants who are normally employed within the territory of one local union (home local) may be temporarily employed within the territory of another local union (reciprocating local). When a participant of the home local works in the territory of reciprocating local, the latter is to make contributions to the formers' fringe benefit plans on the participant's behalf. Monies received by the Plan on behalf of persons from outside participating local unions are forwarded to their home local fringe benefit plans. The Plan uses the same recognition and measurement criteria for such revenue as for all other contractor contribution revenue. Amounts paid to other plans under the terms of reciprocity agreements are not reflected in the statements of changes in net assets available for benefits, as the amounts received are not revenue earned by the Plan, and the corresponding payments are not an expense of the Plan. The Plan recognizes a liability upon receiving reciprocal contributions on behalf of non-participants working within the jurisdiction of the local union, and recognizes a decrease in that liability upon remitting those contributions to the appropriate plan. Employer contributions included reciprocal contributions of $1,551,914 and $1,576,710 for the years ended May 31, 2025 and 2024, respectively, from various other welfare plans under the terms of reciprocity agreements. The Plan remitted a total of $275,871 and $370,655 in reciprocal contributions to various other welfare plans under the terms of reciprocity agreements for the years ended May 31, 2025 and 2024, respectively. A total of $19,914 and $14,129 in reciprocity payments was owed to the other plans at May 31, 2025 and 2024, respectively. Such amounts are included in accounts payable and accrued expenses in the statements of net assets available for benefits.

Benefit Payments - The Plan is generally self-funded for all medical, prescription drug, vision, dental and dependent life benefits. Participant life and accidental death and dismemberment benefits are provided under a nonexperience-rated insurance contract. Effective January 1, 2024, the Plan was amended to provide a fully insured Medicare Advantage Plan for Medicare eligible retirees.

Stop-Loss Insurance - The Plan maintains a stop-loss arrangement with Union Labor Life Insurance Company in an effort to limit its exposure for self-insured benefits. During the years ended May 31, 2025 and 2024, under the terms of the contract, individual participant claims incurred within the contract year in excess of $500,000 are reimbursed to the Plan.

Prescription Drug Rebates - The Plan utilizes a pharmacy benefit manager (PBM) who periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable.

Transitional Reinsurance Fee Refund - The Plan opted into the transitional reinsurance fee class action lawsuit which challenged the legality of requiring self-insured multiemployer welfare plans to pay the transitional reinsurance fees as mandated by the Affordable Care Act. Judgment in favor of the plaintiffs was entered on May 12, 2023 in the United States Court of Federal Claims. As part of this judgment, the Plan was awarded a net recovery in the amount of $140,091 which was received in January 2025.

Note 1. Summary of Significant Accounting Policies (continued)

Subrogation Income - Claims that are reimbursed pursuant to subrogation matters are recorded upon settlement. Subrogation matters involve third parties considered to be responsible for claims paid by the Plan from whom the Plan seeks reimbursement.

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

Benefit Obligations - Benefit obligations are estimated by the Plan's actuary in accordance with accepted actuarial principles, based on claims cost studies, Plan benefits, eligibility counts, claims experience and other data as considered necessary. Health claims incurred by retired participants but not reported at year end are included in postretirement benefit obligations. The obligation for participants' continuing eligibility represents an estimate of claims which will be due the following year for participants who had been credited with sufficient hours prior to May 31 to maintain eligibility after year end. The estimated cost of participants' continuing eligibility is determined using active eligibility totals and a projected per capita benefits cost provided by the Plan's actuary.

Health Reimbursement Arrangement (HRA) Accounts - Included in net assets available for benefits are amounts available to reimburse participants for qualifying medical expenses totaling approximately $1,560,000 as of both May 31, 2025 and 2024. There were no amounts approved for payment from HRA accounts that were not yet paid at either May 31, 2025 or 2024.

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

Leases - The Plan leases office space from a related party, and office equipment from unrelated parties, as described in Note 11. Due to the immaterial nature of the amounts owed pursuant to the leasing agreements, the Plan has not adopted the provisions of accounting guidance for leases required by generally accepted accounting principles.

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

Subsequent Events - Subsequent events have been evaluated through October 30, 2025, which is the date the financial statements were available to be issued.

Note 2. Description of the Plan

The Plan was established during 1950 as a result of a collective bargaining agreement to provide healthcare and death benefits for eligible participants and their dependents. The Plan is a multiemployer welfare plan subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

To become initially eligible, a participant must be credited with contributions of at least 240 hours during a calendar quarter. To remain eligible, a participant must be credited with at least 240 hours per quarter or 960 hours in the four consecutive preceding calendar quarters.

The Plan provides that participants who earn eligibility during a calendar quarter become insured for a three month period beginning on the first day of the third month following the end of the quarter during which eligibility was earned.

A participant who would otherwise lose eligibility because of insufficient contributions may continue eligibility by making self-payments to the Plan.

Effective January 1, 2024, the Plan offers a fully insured Medicare Advantage and Prescription Drug plan through Humana for eligible retired participants.

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

The Plan also offers a Health Reimbursement Arrangement (HRA) program. An HRA is a recordkeeping account that the Plan sets up and maintains on behalf of participants to keep track of contributions, reimbursements and a participant's available balance. Each HRA is funded exclusively through contributions made on a participant's behalf by a contractor that contributes to the Plan under a collective bargaining or participation agreement. All contributions credited to a participant's HRA are assets of the Plan. Contribution amounts are determined by the Board of Trustees and subject to change or discontinuance at any time. Participants are not vested in the contributions made on their behalf, and their available balance may be used only for certain health care expenses not otherwise covered under the Plan and to make self-payments to continue eligibility under the Plan. No earnings are credited to the HRA accounts. The HRA benefit to which a participant is entitled is the benefit that can be provided from the participant's HRA account. Unused credits in a participant's HRA are forfeited after any two year period that the participant is not covered by the Plan and there is no account activity. Total forfeitures for the years ended May 31, 2025 and 2024 were approximately $39,000 and $47,000 respectively, under the provisions of the Plan.

The Plan may be amended from time to time by the Trustees at their sole discretion. Participants should refer to the summary plan description for more complete information.

Note 3. Priorities upon Termination

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy, or make provisions to satisfy, the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any assets to be used for or diverted to purposes other than the exclusive benefit of the participants.

Note 4. Fair Value Measurements

The *Fair Value Measurements and Disclosures* Topic of the FASB Accounting Standards Codification established a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The following describes the three levels of the fair value hierarchy.

Basis of Fair Value Measurement

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

The following tables set forth, by level within the fair value hierarchy, the Plan's investment assets at fair value as of May 31, 2025 and 2024. As required, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. In accordance with generally accepted accounting principles, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in the following tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits:

Note 4. Fair Value Measurements (continued)

		Fair Value Measurements at 5/31/25 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	$ 78,035,956	$ 78,035,956	$ -	$ -
Money market fund	171,818	171,818	-	-
	78,207,774	$ 78,207,774	$ -	$ -
Investments measured at net asset value:				
Commingled investment funds	64,646,579			
Total	$ 142,854,353			

		Fair Value Measurements at 5/31/24 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	$ 75,259,928	$ 75,259,928	$ -	$ -
Money market fund	167,961	167,961	-	-
	75,427,889	$ 75,427,889	$ -	$ -
Investments measured at net asset value:				
Commingled investment funds	65,639,235			
Total	$ 141,067,124			

Level 1 Measurements

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

The money market fund represents shares held in a mutual fund.

Measurements Using Net Asset Value as a Practical Expedient

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

Note 4. Fair Value Measurements (continued)

Measurements Using Net Asset Value as a Practical Expedient (continued)

The commingled investment funds are direct filing entities (DFEs) and file a Form 5500 annual report with the U.S. Department of Labor. The Plan is not required to disclose the significant investment strategies of DFE investments. Redemptions of these investments are available monthly without notice.

Note 5. Tax Status

The Plan's notice of exemption is dated February 15, 1952, in which the Internal Revenue Service stated that the trust established under the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the notice of exemption. The Plan's administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. They therefore believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

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

Note 6. Participation in Multiemployer Plans

Defined Benefit Pension Plans

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

Note 6. Participation in Multiemployer Plans (continued)

Defined Benefit Pension Plans (continued)

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

Pension Plan	EIN/PN	Pension Protection Act Zone Status		Contributions		Most Recently Available Annual Report (Form 5500)
		2025	2024	2025	2024	
Administrative District Council 1 Pension Fund	36-6489098/001	Green as of 6/1/2025	Green as of 6/1/2024	$ 414,180	$ 395,280	5/31/2024
International Union of Bricklayers and Allied Craftworkers Local Union Officers & Employees Pension Plan	53-0038250/002	Green as of 1/1/2025	Green as of 1/1/2024	60,278	58,823	12/31/2024
Other				4,160	4,160	
			Total	$ 478,618	$ 458,263	

Contributions to the significant plans are made monthly under the terms of participation agreements, which do not have an expiration date. The Plan's contributions do not represent more than 5% of the total contributions to these plans as indicated in the plans' most recent available annual reports.

Defined Contribution Retirement Plan

The Plan's full-time employees are also covered by a multiemployer defined contribution retirement plan. Contributions to the defined contribution plan are made monthly under the terms of a participation agreement. Contributions to this plan for the years ended May 31, 2025 and 2024 totaled $122,897 and $126,232 respectively.

Note 6. Participation in Multiemployer Plans (continued)

Welfare Plan that Provides Postretirement Benefits

All of the Plan's employees are covered by a multiemployer health and welfare plan that provides medical benefits to retirees and eligible employees working under collective bargaining or participation agreements, and their dependents. Contributions for the years ended May 31, 2025 and 2024 totaled $356,616 and $366,000 respectively.

Note 7. Related Organizations

The Plan shares certain common governance with Administrative District Council 1 of Illinois, Administrative District Council 1 Pension Fund (Pension Fund), Bricklayers and Stone Masons of Illinois District Council No. 1, B.A.C. Annuity Trust Fund (Annuity Fund), and District Council Training Center Fund (DCTC).

The Plan shares facilities, equipment and staff with certain related organizations. All shared administrative costs are initially paid by the Plan and subsequently allocated to the respective organizations. Reimbursed shared expenses are netted with administrative expenses and, for the years ended May 31, 2025 and 2024, were as follows:

	2025	2024
Pension Fund	$ 785,245	$ 741,284
Annuity Fund	488,335	477,344
DCTC	17,385	15,762
Total	$ 1,290,965	$ 1,234,390

The Plan leases its main office space from Administrative District Council 1 of Illinois under the terms of a formal lease agreement. Further details regarding this lease can be found in Note 11.

Contributions for this Plan and other affiliated organizations are received and deposited in a lockbox account. The Plan is responsible for processing the contributions deposited in the lockbox account and assesses a 1% processing fee to unrelated organizations for the cost of this service. On a regular basis, contributions due to the Plan are transferred from the lockbox account into the Plan's cash account. The Plan continually monitors lockbox posting activity and makes adjustments as necessary. Contractors and participants are given proper credit based on reports submitted to the lockbox account.

Note 8. Funding Policy

Participating contractors contribute such amounts as specified in the collective bargaining agreement. The most common hourly contribution rate was $12.70 and $12.50 for the years ended May 31, 2025 and 2024, respectively.

In addition to participants being able to self-pay to continue coverage, participant contributions are allowed to provide COBRA benefits and benefits to retired and disabled participants. Participant contribution rates are determined annually. Participant contributions to provide benefits under COBRA were paid at a monthly rate ranging from $404 to $2,525 and from $205 to $2,380 for the years ended May 31, 2025 and 2024, respectively, depending on the participant's coverage option. The monthly contribution rates for retirees and retiree spouses ranged from $60 to $900 for the years ended May 31, 2025 and 2024, depending on the participant's retirement date and coverage option.

Note 9. Postretirement Benefit Obligations

The postretirement benefit obligation represents the total actuarial present value of those estimated future benefits that are attributed to employee service rendered to May 31, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating contractors.

Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The present value of the expected postretirement benefit obligations 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.

Postretirement benefit obligations are net of projected retiree contributions, which the actuary calculated to be approximately 61% and 79% as of May 31, 2025 and 2024, respectively.

Note 9. Postretirement Benefit Obligations (continued)

Some of the more significant actuarial assumptions were as follows:

	2025	2024
Discount rate	5.50%	5.25%
Medical trend rate:		
Non-Medicare medical and prescription drug	9.00%	7.25%
Medicare medical	48.00%	15.50%
Medicare prescription drug	48.00%	15.50%

The postretirement mortality rates for healthy lives were based on 95% of Pri-2012 Blue Collar Healthy Annuitant Headcount Weighted Mortality Tables, projected generationally from 2012 with Scale MP-2020.

The postretirement mortality rates for disabled lives were based on 95% of Pri-2012 Disabled Retiree Headcount Weighted Mortality Tables, projected generationally from 2012 with Scale MP-2020.

The postretirement mortality rates for surviving spouse lives were based on 95% of Pri-2012 Blue Collar Contingent Survivor Headcount Weighted Mortality Tables, projected generationally from 2012 with Scale MP-2020.

For 2025, the medical trend rate was assumed to decrease .25% per year until the year 2044, at which time the rate was assumed to remain level at 4.5% for non-Medicare medical and prescription drug benefits, decrease .40% per year until the year 2044, at which time the rate was assumed to remain level at 4.5% for both Medicare medical and prescription drug benefits. For 2024, the medical trend rate was assumed to decrease .25% per year until the year 2036, at which time the rate was assumed to remain level at 4.5% for non-Medicare medical and prescription drug benefits, decrease .35% per year until the year 2036, at which time the rate was assumed to remain level at 4.5% for both Medicare medical and prescription drug benefits.

The trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, the obligation would increase as of May 31, 2025 and 2024 by $11,876,144 and $4,258,825 respectively.

Effective January 1, 2025, a new plan amendment took effect to provide a dental benefit for all participants.

Note 9. Postretirement Benefit Obligations (continued)

Effective January 1, 2024, a new plan amendment took effect to implement a Medicare Advantage and Prescription Drug plan for Medicare eligible retired participants.

Changes in actuarial assumptions for the year ended May 31, 2025 were the result of increasing the discount rate from 5.25% to 5.50%, updating the valuation-year per capita health costs, retiree contribution rates remaining unchanged rather than increasing as expected and updating the future trend rates on per capita health costs, retiree contribution rates and PPO fees.

Changes in actuarial assumptions for the year ended May 31, 2024 were the result of increasing the discount rate from 5.00% to 5.25%, updating the valuation-year per capita health costs, retiree contribution rates remaining unchanged rather than increasing as expected and updating the future trend rates on per capita health costs, retiree contribution rates and PPO fees.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added a prescription drug benefit under Medicare Part D providing a federal subsidy to Plan sponsors of retiree health care benefit plans that provide a prescription drug benefit to Medicare-eligible retirees. The Plan has been determined to be actuarially equivalent to the Medicare Part D Standard Benefit. The Plan's postretirement benefit obligations as of May 31, 2025 and 2024 include a reduction for the subsidy of approximately $77,000 and $68,000 respectively.

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

The funding of the postretirement benefit obligations is not covered by the contribution rate provided by the current bargaining agreement. The Plan empowers the Board of Trustees to increase or decrease annually the amount of self-payments by eligible retired participants, and to modify the terms and conditions under which retiree eligibility may be maintained; therefore, the annual cost of the Plan can be reduced or eliminated prospectively by action of the Board of Trustees.

Note 10. Risks and Uncertainties

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

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

Note 10. Risks and Uncertainties (continued)

The Plan has a significant portion of its assets invested in one mutual fund, Vanguard Total Stock Market Index Fund, which represented approximately 37% and 36% of the Plan's net assets available for benefits as of May 31, 2025 and 2024, respectively.

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 11. Operating Leases

The Plan is obligated under the following leases:

- Office space in Elmhurst, Illinois under a ten year lease which expires in May 2030, with a current monthly base rent of $8,879;
- A folding inserter machine and a postage machine for $3,231 per month under a 51-month lease through January 2028; and
- A copier machine for $773 per month under a 60-month lease which expires in August 2027.

The following provides a summary by year of future rental payments required under the various leases:

Year ending May 31,	
2026	$ 154,595
2027	134,712
2028	108,861
2029	106,542
2030	106,542
Total	$ 611,252

Office rental expense totaled $106,542 for each of the years ended May 31, 2025 and 2024. Expenses related to the office equipment leases totaled $49,364 and $46,882 for the years ended May 31, 2025 and 2024, respectively.

Note 12. Property and Equipment

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

	2025	2024
Computer and office equipment	$ 360,065	$ 424,445
Furniture and fixtures	160,238	167,168
Automobiles	42,898	42,898
	563,201	634,511
Less accumulated depreciation	(489,325)	(561,737)
Net property and equipment	$ 73,876	$ 72,774

All shared property and equipment is purchased and recorded on the books of the Plan. Use of the property and equipment is shared by the Plan, Pension Fund, Annuity Fund and DCTC. The Plan is reimbursed for the related organizations' proportionate share of all costs and expenses relating to property and equipment.

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:

	2025	2024
Net assets available for benefits per the financial statements	$ 148,817,559	$ 147,810,713
Less - benefit obligations currently payable	(5,610,915)	(4,297,071)
Net assets available for benefits per the Form 5500	$ 143,206,644	$ 143,513,642

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

Benefits paid to or for participants per the financial statements	$ 37,583,411
Add - amounts currently payable at end of year	5,610,915
Less - amounts currently payable at beginning of year	(4,297,071)
Benefits paid to or for participants per the Form 5500	$ 38,897,255

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

Report of Independent Auditors on Supplemental Schedules

To the Participants and Trustees of
Administrative District Council 1 Welfare Fund

We have audited the financial statements of Administrative District Council 1 Welfare Fund (the Plan) as of and for the years ended May 31, 2025 and 2024, and our report thereon dated October 30, 2025, which expressed an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. Supplemental Schedules 1 and 2 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Legacy Professionals LLP

Westchester, Illinois

October 30, 2025

FOOTNOTES STATEMENT 1

SCHEDULE C, PART 2, COLUMN D:
THE AMOUNT OF DIRECT COMPENSATION ATTRIBUTABLE TO PLAN EMPLOYEES AND TRUSTEES AND REPORTED ON SCHEDULE C HAS BEEN DETERMINED IN ACCORDANCE WITH DEPARTMENT OF LABOR RULES AND REGULATIONS FOR COMPLETING FORM 5500. THESE AMOUNTS MAY CONSIST OF ELEMENTS CONSIDERED TO BE TAXABLE AS WELL AS NON-TAXABLE UNDER THE CURRENT INTERNAL REVENUE CODE.

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 2

NAME	SERVICE CODES
BRIDGEWAY BENEFIT TECHNOLOGIES	15
BRIDGEWAY BENEFIT TECHNOLOGIES	16
BRIDGEWAY BENEFIT TECHNOLOGIES	49
BRIDGEWAY BENEFIT TECHNOLOGIES	55
MIDWEST INSTITUTIONAL TRUST CO	19
MIDWEST INSTITUTIONAL TRUST CO	31
MIDWEST INSTITUTIONAL TRUST CO	49
MIDWEST INSTITUTIONAL TRUST CO	51
MIDWEST INSTITUTIONAL TRUST CO	62

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
DUE FROM RELATED ENTITIES	96,578.	181,463.
CONTRIBUTION PROCESSING FEES	4,241.	4,381.
PREPAID EXPENSE	25,188.	145,133.
BENEFIT REBATES	1,132,532.	948,792.
SUBROGATION REFUNDS	137,318.	42,670.
DUE FROM LOCKBOX ACCOUNT - CONTRIBUT	1,309,782.	1,399,892.
TOTAL TO SCHEDULE H, LINE 1B(3)	2,705,639.	2,722,331.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 4

DESCRIPTION	BEGINNING	ENDING
DEFERRED CONTRIBUTIONS	33,314.	24,548.
TOTAL TO SCHEDULE H, LINE 1J	33,314.	24,548.

SCHEDULE H OTHER INCOME STATEMENT 5

DESCRIPTION	AMOUNT
CONTRIBUTION PROCESSING FEES	63,652.
SUBROGATION REFUNDS	116,198.
ALLOCATED SHARED EXPENSE INCOME	1,290,965.
MISCELLANEOUS INCOME	97,430.
MEDICARE PART D SUBSIDY	13,287.
PRESCRIPTION DRUG REBATES	2,885,216.
JAB AND OTHER COLLECTION RELATED INCOME	76,973.
STOP-LOSS INSURANCE PROCEEDS	291,197.
TRADITIONAL REINSURANCE FEE REFUND	140,091.
TOTAL TO SCHEDULE H, LINE 2C	4,975,009.

SCHEDULE H OTHER PAYMENTS TO PROVIDE BENEFITS STATEMENT 6

DESCRIPTION	AMOUNT
PPO AND ADMINISTRATIVE FEES	839,128.
CLAIMS RELATED EXPENSES	91,091.
TOTAL TO SCHEDULE H, LINE 2E(3)	930,219.

SCHEDULE H OTHER ADMINISTRATIVE EXPENSES STATEMENT 7

DESCRIPTION	AMOUNT
DATA PROCESSING EXPENSE	1,580.
INSURANCE	75,569.
POSTAGE AND DELIVERY	124,102.
PRINTING AND STATIONERY	14,170.
PAYROLL TAXES	92,808.
RENT	106,542.
DEPRECIATION EXPENSE	24,646.
OFFICE AND COMPUTER RELATED EXPENSE	288,154.
TELEPHONE EXPENSE	22,997.
FEES MANDATED BY ACA	14,164.
MEMBERSHIP DUES	6,232.
TOTAL TO SCHEDULE H, LINE 2I(11)	770,964.

SUPPLEMENTAL SCHEDULE 1

Administrative District Council No. 1 Welfare Fund
EIN 36-2150067
Y/E: 5/31/2025

	Market Value	Cost
Interest Bearing Cash		
GS Financial Square Government	171,818	171,818
	171,818	
Common/Collective Trusts		
NIS High Yield QP Fund	2,314,889	1,825,327
NIS Total Absolute Return QP Fund	4,304,138	3,403,729
NIS Core Fixed Income QP Fund	15,814,212	14,884,012
NIS Intermediate Fixed Income QP Fund	25,531,964	22,446,264
	47,965,203	
103-12 Investment Entities		
Washington Capital Real Asset Income Fund	16,681,376	14,800,000
	16,681,376	
Registered Investment Company		
Baron International Growth Fund	-	-
American Europacific Growth Fund	1,184,788	1,045,984
Harding Loevner International Equity	1,253,626	1,126,159
Fidelity Advisor International	1,291,440	956,387
T. Rowe Price International Discovery	661,589	816,601
Vanguard Total Stock Market Index Fund	55,143,618	29,499,494
Baird Intermediate Bond Fund	18,500,895	19,429,413
Total	78,035,956	

Admin Dist Council NO1-Rollup

Account Number:
Statement Period: 06/01/24 through 05/31/25

5% Transactions

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
- Baird Intermediate Bond Fd Instl #70							
Purchased 234146.341 Shs 06/05/24		.00	.00	10.250	2,400,000.00	2,400,000.00	.00
Sold 145914.397 Shs 06/24/24		.00	.00	10.280	1,500,000.00	1,601,452.58	- 101,452.58
Recd 2266.493 Shs As A Reinvested Div of $ 10.250 Per Sh		.00	.00	10.250	23,231.55	23,231.55	.00
Recd 4095.792 Shs As A Reinvested Div of $ 10.250 Per Sh		.00	.00	10.250	41,981.87	41,981.87	.00
Recd 2229.194 Shs As A Reinvested Div of $ 10.290 Per Sh		.00	.00	10.290	22,938.41	22,938.41	.00
Recd 4028.389 Shs As A Reinvested Div of $ 10.290 Per Sh		.00	.00	10.290	41,452.12	41,452.12	.00
Recd 2171.330 Shs As A Reinvested Div of $ 10.480 Per Sh		.00	.00	10.480	22,755.54	22,755.54	.00
Recd 3923.823 Shs As A Reinvested Div of $ 10.480 Per Sh		.00	.00	10.480	41,121.66	41,121.66	.00
Recd 2244.645 Shs As A Reinvested Div of $ 10.570 Per Sh		.00	.00	10.570	23,725.90	23,725.90	.00
Recd 4056.311 Shs As A Reinvested Div of $ 10.570 Per Sh		.00	.00	10.570	42,875.21	42,875.21	.00
Sold 76481.836 Shs 10/04/24		.00	.00	10.460	800,000.00	839,005.74	- 39,005.74
Recd 2322.302 Shs As A Reinvested Div of $ 10.370 Per Sh		.00	.00	10.370	24,082.27	24,082.27	.00
Recd 3938.473 Shs As A Reinvested Div of $ 10.370 Per Sh		.00	.00	10.370	40,841.96	40,841.96	.00
Recd 2441.756 Shs As A Reinvested Div of $ 10.350 Per Sh		.00	.00	10.350	25,272.17	25,272.17	.00
Recd 4141.058 Shs As A Reinvested Div of $ 10.350 Per Sh		.00	.00	10.350	42,859.95	42,859.95	.00

Admin Dist Council NO1-Rollup

Account Number:
Statement Period: **06/01/24 through 05/31/25**

5% Transactions

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
Recd 2717.263 Shs As A Reinvested Div of $ 10.250 Per Sh		.00	.00	10.250	27,851.95	27,851.95	.00
Recd 4608.301 Shs As A Reinvested Div of $ 10.250 Per Sh		.00	.00	10.250	47,235.09	47,235.09	.00
Sold 126336.249 Shs 01/22/25		.00	.00	10.290	1,300,000.00	1,386,404.03	- 86,404.03
Recd 2090.832 Shs As A Reinvested Div of $ 10.300 Per Sh		.00	.00	10.300	21,535.57	21,535.57	.00
Recd 3166.091 Shs As A Reinvested Div of $ 10.300 Per Sh		.00	.00	10.300	32,610.74	32,610.74	.00
Recd 2221.254 Shs As A Reinvested Div of $ 10.390 Per Sh		.00	.00	10.390	23,078.83	23,078.83	.00
Recd 3363.584 Shs As A Reinvested Div of $ 10.390 Per Sh		.00	.00	10.390	34,947.65	34,947.65	.00
Purchased 144369.586 Shs 03/14/25		.00	.00	10.390	1,500,000.00	1,500,000.00	.00
Recd 2345.046 Shs As A Reinvested Div of $ 10.370 Per Sh		.00	.00	10.370	24,318.13	24,318.13	.00
Recd 4034.854 Shs As A Reinvested Div of $ 10.370 Per Sh		.00	.00	10.370	41,841.43	41,841.43	.00
Sold 144230.769 Shs 04/08/25		.00	.00	10.400	1,500,000.00	1,583,653.84	- 83,653.84
Recd 2221.891 Shs As A Reinvested Div of $ 10.410 Per Sh		.00	.00	10.410	23,129.89	23,129.89	.00
Recd 3366.522 Shs As A Reinvested Div of $ 10.410 Per Sh		.00	.00	10.410	35,045.49	35,045.49	.00
Recd 2275.691 Shs As A Reinvested Div of $ 10.380 Per Sh		.00	.00	10.380	23,621.67	23,621.67	.00
Recd 3448.037 Shs As A Reinvested Div of $ 10.380 Per Sh		.00	.00	10.380	35,790.62	35,790.62	.00

Admin Dist Council NO1-Rollup

Account Number:
Statement Period: 06/01/24 through 05/31/25

5% Transactions

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
Purchases	26	.00	.00	10.314	4,664,145.67	4,664,145.67	.00
Sales	4	.00	.00	10.346	5,100,000.00	5,410,516.19	- 310,516.19
- GS Fin Sq Gov #466							
Purchases	73	.00	.00	1.000	4,915,651.51	4,915,651.51	.00
Sales	11	.00	.00	1.000	4,911,794.24	4,911,794.24	.00
- Vanguard Total Stock Market Index Fd Class I #855							
Sold 18927.444 Shs 06/04/24		.00	.00	126.800	2,400,000.00	1,362,965.25	1,037,034.75
Recd 773.134 Shs As A Reinvested Div of $ 130.270 Per Sh		.00	.00	130.270	100,716.21	100,716.21	.00
Recd 642.213 Shs As A Reinvested Div of $ 130.270 Per Sh		.00	.00	130.270	83,661.14	83,661.14	.00
Recd 673.067 Shs As A Reinvested Div of $ 137.340 Per Sh		.00	.00	137.340	92,439.06	92,439.06	.00
Recd 559.091 Shs As A Reinvested Div of $ 137.340 Per Sh		.00	.00	137.340	76,785.62	76,785.62	.00
Sold 5084.623 Shs 10/04/24		.00	.00	137.670	700,000.00	355,872.76	344,127.24
Sold 10333.425 Shs 11/27/24		.00	.00	145.160	1,500,000.00	723,236.41	776,763.59
Recd 700.406 Shs As A Reinvested Div of $ 143.130 Per Sh		.00	.00	143.130	100,249.07	100,249.07	.00
Recd 532.432 Shs As A Reinvested Div of $ 143.130 Per Sh		.00	.00	143.130	76,207.01	76,207.01	.00
Sold 4783.054 Shs 01/22/25		.00	.00	146.350	700,000.00	334,765.95	365,234.05
Purchased 7412.898 Shs 03/14/25		.00	.00	134.900	1,000,000.00	1,000,000.00	.00
Recd 774.975 Shs As A Reinvested Div of $ 135.860 Per Sh		.00	.00	135.860	105,288.06	105,288.06	.00

Admin Dist Council NO1-Rollup

Account Number:
Statement Period: 06/01/24 through 05/31/25

5% Transactions

Description	Number of Purchases / Sales	Commissions	Other Costs	Unit Price	Proceeds of Purchase / Sale	Cost of Purchase / Sale	Realized Gain / Loss
Recd 598.405 Shs As A Reinvested Div of $ 135.860 Per Sh		.00	.00	135.860	81,299.33	81,299.33	.00
Purchases	9	.00	.00	135.525	1,716,645.50	1,716,645.50	.00
Sales	4	.00	.00	135.451	5,300,000.00	2,776,840.37	2,523,159.63

*** Transactions noted by an asterisk are in themselves greater than 5% of beginning Plan Year market values.**