

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110
1210-0089

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: AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND
1b Three-digit plan number (PN): 001
1c Effective date of plan: 06/01/2020
2a Plan sponsor's name (employer, if for a single-employer plan): BD OF TRUSTEES AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND
2b Employer Identification Number (EIN): 85-0774781
2c Plan Sponsor's telephone number: 516-872-6690
2d Business code (see instructions): 525920

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

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

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include Joseph Giovenco (plan administrator) and Daniel Gatto (employer/plan sponsor).

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1558
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1304
	6a(2)	1207
	6b	72
	6c	226
	6d	1505
	6e	1
	6f	1506
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	11

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
1A

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

SCHEDULE MB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
---	--	--

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

▶ **Round off amounts to nearest dollar.**
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>BD OF TRUSTEES AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND</u>	D Employer Identification Number (EIN) <u>85-0774781</u>

E Type of plan: (1) Multiemployer Defined Benefit (2) Money Purchase (see instructions)

1a Enter the valuation date: Month 06 Day 01 Year 2024

b Assets	
(1) Current value of assets	1b(1) <u>16108157</u>
(2) Actuarial value of assets for funding standard account	1b(2) <u>15821539</u>
c (1) Accrued liability for plan using immediate gain methods	1c(1) <u>18288970</u>
(2) Information for plans using spread gain methods:	
(a) Unfunded liability for methods with bases	1c(2)(a)
(b) Accrued liability under entry age normal method	1c(2)(b)
(c) Normal cost under entry age normal method	1c(2)(c)
(3) Accrued liability under unit credit cost method	1c(3) <u>18288970</u>
d Information on current liabilities of the plan:	
(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1)
(2) "RPA '94" information:	
(a) Current liability	1d(2)(a) <u>28784048</u>
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b) <u>2578739</u>
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c) <u>829271</u>
(3) Expected plan disbursements for the plan year	1d(3) <u>829271</u>

Statement by Enrolled Actuary
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE <u>ANTHONY BERLOTTI</u> Type or print name of actuary <u>KEYSTONE 74 BENEFITS AND ADMIN</u> Firm name <u>3031 WALTON ROAD - BUILDING B</u> <u>PLYMOUTH MEETING, PA 19462</u> Address of the firm	<u>02/25/2026</u> Date <u>23-08756</u> Most recent enrollment number <u>267-606-1379</u> Telephone number (including area code)
--	--

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	2a	16108157
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	58	3417054
(2) For terminated vested participants	195	4035146
(3) For active participants:		
(a) Non-vested benefits		5377964
(b) Vested benefits		15953884
(c) Total active	1304	21331848
(4) Total	1557	28784048
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	55.96 %

3 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM/DD/YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	
12/01/2024	2338116	0				
06/01/2025	436645	0				
			Totals ▶	3(b)	2774761	
(d) Total withdrawal liability amounts included in line 3(b) total					3(c)	0
					3(d)	0

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)).....	4a	86.5 %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	4b	N
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d If the plan is in critical status or critical and declining status, does line 1(c) reflect any benefit reductions for the first time (see instructions)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	4e	
f If the plan is in critical status or critical and declining status, and is: • Projected to emerge from critical status within 30 years, enter the plan year in which it is projected to emerge; • Projected to become insolvent within 30 years, enter the plan year in which insolvency is expected and check here..... <input type="checkbox"/> • Neither projected to emerge from critical status nor become insolvent within 30 years, enter "9999."	4f	

5 Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

a <input type="checkbox"/> Attained age normal	b <input type="checkbox"/> Entry age normal	c <input checked="" type="checkbox"/> Accrued benefit (unit credit)	d <input type="checkbox"/> Aggregate
e <input type="checkbox"/> Frozen initial liability	f <input type="checkbox"/> Individual level premium	g <input type="checkbox"/> Individual aggregate	h <input type="checkbox"/> Shortfall
i <input type="checkbox"/> Other (specify):			
j If box h is checked, enter period of use of shortfall method	5j		
k Has a change been made in funding method for this plan year?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
m If line k is "Yes," and line l is "No," enter the date (MM/DD/YYYY) of the ruling letter (individual or class) approving the change in funding method	5m		

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability.....	6a	3.63 %
b Rates specified in insurance or annuity contracts.....	Pre-retirement	Post-retirement
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
c Mortality table code for valuation purposes:		
(1) Males	6c(1)	9P
(2) Females	6c(2)	9FP
d Valuation liability interest rate	6d	7.00 %
e Salary scale	6e	4.00 % <input type="checkbox"/> N/A
f Withdrawal liability interest rate:		
(1) Type of interest rate	6f(1)	<input checked="" type="checkbox"/> Single rate <input type="checkbox"/> ERISA 4044 <input type="checkbox"/> Other <input type="checkbox"/> N/A
(2) If "Single rate" is checked in (1), enter applicable single rate	6f(2)	7.00 %
g Estimated investment return on actuarial value of assets for year ending on the valuation date	6g	7.0 %
h Estimated investment return on current value of assets for year ending on the valuation date	6h	12.3 %
i Expense load included in normal cost reported in line 9b	6i	<input type="checkbox"/> N/A
(1) If expense load is described as a percentage of normal cost, enter the assumed percentage.....	6i(1)	%
(2) If expense load is a dollar amount that varies from year to year, enter the dollar amount included in line 9b.....	6i(2)	426929
(3) If neither (1) nor (2) describes the expense load, check the box	6i(3)	<input type="checkbox"/>

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	-268423	-27543

8 Miscellaneous information:

a If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM/DD/YYYY) of the ruling letter granting the approval	8a	
b Demographic, benefit, and contribution information		
(1) Is the plan required to provide a projection of expected benefit payments? (See instructions) If "Yes," see instructions for required attachment.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
(2) Is the plan required to provide a Schedule of Active Participant Data? (See instructions).		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
(3) Is the plan required to provide a projection of employer contributions and withdrawal liability payments? (See instructions) If "Yes," attach a schedule.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d If line c is "Yes," provide the following additional information:		
(1) Was an extension granted automatic approval under section 431(d)(1) of the Code?		<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended ..	8d(2)	
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?		<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	8d(4)	
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension	8d(5)	
(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e If box 5h is checked or the plan received an amortization extension for this plan year under Code section 431(d), enter the difference between the amount necessary to satisfy the plan's minimum funding standard for this plan year and the amount that would have been necessary without using the shortfall method or extending the amortization period(s).	8e	

9 Funding standard account statement for this plan year:

Charges to funding standard account:

a Prior year funding deficiency, if any	9a	
b Employer's normal cost for plan year as of valuation date.....	9b	1878554

c Amortization charges as of valuation date:		Outstanding balance	
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	6085656	667367
(2) Funding waivers	9c(2)	0	0
(3) Certain bases for which the amortization period has been extended.....	9c(3)	0	0
d Interest as applicable on lines 9a, 9b, and 9c.....	9d		178214
e Total charges. Add lines 9a through 9d.....	9e		2724135
Credits to funding standard account:			
f Prior year credit balance, if any.....	9f		3349802
g Employer contributions. Total from column (b) of line 3.....	9g		2774761
		Outstanding balance	
h Amortization credits as of valuation date.....	9h	268423	27543
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i		316640
j Full funding limitation (FFL) and credits:			
(1) ERISA FFL (accrued liability FFL).....	9j(1)	8234492	
(2) "RPA '94" override (90% current liability FFL)	9j(2)	12877304	
(3) FFL credit	9j(3)		0
k (1) Waived funding deficiency	9k(1)		
(2) Other credits	9k(2)		
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)	9l		6468746
m Credit balance: If line 9l is greater than line 9e, enter the difference	9m		3744611
n Funding deficiency: If line 9e is greater than line 9l, enter the difference	9n		
o Current year's accumulated reconciliation account:			
(1) Due to waived funding deficiency accumulated prior to the current plan year.....	9o(1)		0
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:			
(a) Reconciliation outstanding balance as of valuation date	9o(2)(a)		0
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)).....	9o(2)(b)		0
(3) Total as of valuation date.....	9o(3)		0
10 Contribution necessary to avoid an accumulated funding deficiency. (see instructions.).....	10		
11 Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

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

A Name of plan AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	D Employer Identification Number (EIN) 85-0774781	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

VANGUARD GROUP INC.

23-1945930

(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

(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

(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)

MCCARTHY & PREECE

84-3667887

(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 50	NONE	60000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PRISCILLA FARDUCHI

48-2849057

(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 50	EMPLOYEE	51464	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JOSEPH GIOVINCO

46-2849057

(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 50	EMPLOYEE	26496	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

EASTERN STATES JOINT BOARD

46-2849057

(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 50	RELATED ORGANIZATION	26461	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WEAVER & TIDWELL LLP

75-0786316

(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 50	NONE	24000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KEYSTONE 74 BENEFITS & ADMIN. LLC

99-2136324

(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 50	NONE	14417	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

QUAN-VEST CONSULTANTS, INC.

11-2559669

(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	12036	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ADP, INC.

22-1467904

(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 50	NONE	9848	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LAWRENCE FISCHER, CPA

52-2326815

(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 50	NONE	7450	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

a Name:	WEAVER & TIDWELL, LLP	b EIN:	75-0786316
c Position:	ACCOUNTANT		
d Address:	ONE PENNSYLVANIA PLAZA, SUITE 3200 NEW YORK, NY 10119	e Telephone:	212-695-5003

Explanation: FUND TRUSTEES CHANGED ACCOUNTANT THROUGH NORMAL BIDDING PROCESS

a Name:	BRYAN M. MCCORMICK (KBA74)	b EIN:	99-2136324
c Position:	ENROLLED ACTUARY		
d Address:	3031 WALTON ROAD PLYMOUTH MEETING, PA 19462	e Telephone:	267-606-1391

Explanation: DUE TO CHANGES IN KBA74 INTERNAL STAFFING, THE PLAN'S ENROLLED ACTUARY HAS CHANGED FROM BRYAN MCCORMICK TO ANTHONY BERTOLOTTI.

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

Explanation:

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

Explanation:

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

Explanation:

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

For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025	
A Name of plan AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	D Employer Identification Number (EIN) 85-0774781

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	303472	
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	407236	436645
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		10721
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		146620
(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)	622717	1283705
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	14816057	17924802
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	16149482	19802493
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h	41325	22516
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		1346
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	41325	23862
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	16108157	19778631

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)	2774761	
(B) Participants.....	2a(1)(B)		
(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)		2774761
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	2252	
(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)	40770	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		43022
(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)	432693	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		432693
(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)	-28352	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1026053
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		4248177

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	324376	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		324376
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)	111955	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	7450	
(4) IQPA audit fees	2i(4)	24000	
(5) Investment advisory and investment management fees	2i(5)	13466	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	51567	
(8) Legal fees	2i(8)	61556	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)	100262	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		370256
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		694632

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		3553545
l Transfers of assets:			
(1) To this plan.....	2l(1)		116929
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **NOVAK FRANCELLA, LLC**

(2) EIN: **61-1436956**

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	X		1283705
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

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

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

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

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 568066.

SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
--	---	---

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

A Name of plan AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES AMALGAMATED TRANSIT WORKERS LOCAL 854 PENSION FUND	D Employer Identification Number (EIN) 85-0774781	

Part I	Distributions
---------------	----------------------

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>85-0774781</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	0

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)
----------------	---

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... Increase Decrease Both No

Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer **ALLIED TRANSIT CORP**

b EIN **13-3954272**

c Dollar amount contributed by employer

98405

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **30** Year **2028**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **3.0% TO 4.75% OF SALARY**

a Name of contributing employer **EMPIRE STATE BUS**

b EIN **13-3736911**

c Dollar amount contributed by employer

25484

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **30** Year **2028**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **3.0% TO 4.75% OF SALARY**

a Name of contributing employer **EMPIRE CHARTER DRIVERS**

b EIN **11-3622830**

c Dollar amount contributed by employer

66779

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **30** Year **2020**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **3.0% TO 4.00% OF SALARY**

a Name of contributing employer **CBT PARA TRANSIT**

b EIN **20-4507771**

c Dollar amount contributed by employer

6300

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **30** Year **2020**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **4.00% OF SALARY**

a Name of contributing employer **MARCAN TRANSPORTATION**

b EIN **13-2989636**

c Dollar amount contributed by employer

484804

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **09** Day **30** Year **2028**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **3.0% TO 11.50% OF SALARY**

a Name of contributing employer **NORTHSTAR INDUSTRIES**

b EIN **26-0354449**

c Dollar amount contributed by employer

93549

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **12** Day **31** Year **2025**

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): **7.50% OF SALARY**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer Y&M TRANSIT

b EIN 45-4059398 **c** Dollar amount contributed by employer 544760

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 08 Day 31 Year 2027

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): 4.25% TO 6.5% OF SALARY

a Name of contributing employer JSJ SERVICE

b EIN 26-2514556 **c** Dollar amount contributed by employer 263035

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 06 Day 30 Year 2028

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): 5.5% OF SALARY

a Name of contributing employer CONSOLIDATED BUS TRANSIT

b EIN 11-3046431 **c** Dollar amount contributed by employer 595308

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 06 Day 30 Year 2028

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): 5.5% OF SALARY

a Name of contributing employer JOFAZ TRANSPORTATION

b EIN 11-2497713 **c** Dollar amount contributed by employer 591438

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month 08 Day 31 Year 2027

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): 4.25% TO 6.50% OF SALARY

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment).....	14a	
b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14b	
c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14c	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	907.00

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....	16b	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
 Public Equity: 56.0 % Private Equity: 0.0 % Investment-Grade Debt and Interest Rate Hedging Assets: 40.0 %
 High-Yield Debt: 0.0 % Real Assets: 3.0 % Cash or Cash Equivalents: 1.0 % Other: 0.0 %

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation: _____

Part VII IRS Compliance Questions

21a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

Design-based safe harbor method

"Prior year" ADP test

"Current year" ADP test

N/A

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/____ (MM/DD/YYYY) and the Opinion Letter serial number _____.

Attachments Unavailable

Attachments for the selected filing cannot be publicly disclosed over the website as the Department of Labor determined that one or more attachments may contain sensitive personally identifiable information. Please contact the Department of Labor EBSA Public Disclosure Office as noted below in order to request a redacted copy of the document you need.

U.S. Department of Labor
Employee Benefits Security Administration
EBSA Public Disclosure Room
200 Constitution Avenue NW
Washington, DC 20210
Tel 202.693.8673
foiarequests@dol.gov