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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

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

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
SMU DENTAL PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 09/01/1962

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)
SOUTHERN METHODIST UNIVERSITY

3140 DYER ST MS261
6116 N CENTRAL EXPRESSWAY, STE 203
DALLAS, TX 75275-0261

2b Employer Identification Number (EIN)
75-0800689

2c Plan Sponsor's telephone number
214-768-2004

2d Business code (see instructions)
611000

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.	07/31/2026	MAI BUI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	5059
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)**	4934
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	4793
b	Retired or separated participants receiving benefits	**6b**	160
c	Other retired or separated participants entitled to future benefits	**6c**	82
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5035
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**	

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

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

4D

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1) [ ]	Insurance	**(1)** [ ]	Insurance
(2) [ ]	Code section 412(e)(3) insurance contracts	**(2)** [ ]	Code section 412(e)(3) insurance contracts
(3) [ ]	Trust	**(3)** [ ]	Trust
(4) [X]	General assets of the sponsor	**(4)** [X]	General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE C (Form 5500)	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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan	**B** Three-digit plan number (PN) ▶	
SMU DENTAL PLAN		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
SOUTHERN METHODIST UNIVERSITY	75-0800689	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

BLUECROSS BLUESHIELD OF TEXAS

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?
	ASO ADMINISTRATOR-DENTAL	80506	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 ☐

(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
(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

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(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:

Attached to and made a part of
Form 5500
Annual Return/Report of Employee Benefit Plan

Taxpayer Name:	**Southern Methodist University**
Calendar Year:	**1/1/2025 – 12/31/2025**
EIN:	**75-0800689**
ASO Administrator:	**Blue Cross Blue Shield of Texas Inc.**

Dental Plan

Blue Cross Blue Shield of Texas Inc. administers both the SMU self-funded Dental and Medical plans, which are reported separately. The attached "2025 BCBSTX Schedule C" document provides combined information for both plans. However, information specific to the Dental Plan only is presented on this Form 5500.

Form M-1 Compliance Information

Attached to and made a part of
Form 5500
Annual Return/Report of Employee Benefit Plan

Taxpayer Name:	**Southern Methodist University**
Calendar Year:	**1/1/2025 – 12/31/2025**
EIN:	**75-0800689**
ASO Administrator:	**Blue Cross Blue Shield of Texas Inc.**

Form M-1 Compliance Information

The plan reported on this Form 5500 provides welfare benefits, but was not subject to the Form M-1 filing requirements during the plan year above.

BlueCross BlueShield of Texas

FORM 5500 INFORMATION

Customer Name: Southern Methodist University ***Customer Account Number: 090138***
Financial Arrangement: ASO
Coverage Period: 01/01/2025 through 12/31/2025

1. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY OR CONTRACT PERIOD:		Medical	5293
		Dental	5035

2. EXPERIENCE RATED CONTRACTS

Premiums:	Amount billed	$50,686,022.77	
	Amount due but unpaid	$0.00	
	Total Premiums earned		$50,686,022.77
Benefit Charges:	Net Claims paid*	$54,958,318.31	
	Change in claim reserves	$0.00	
	Change in other reserves	$0.00	
	Physician Service Fees	$0.00	
	Total Claims paid		$54,958,318.31
Remainder Of Premium:	Commissions	$247,424.20	
	Service fees	$0.00	
	Drug Rebate Credits (under Pharm./Med.)	($6,216,627.72)	
	Administrative expenses	$1,696,907.98	
	Other (Interest credit)	$0.00	
	Total Retention		($4,272,295.54)
Experience or retroactive rate refunds			$0.00
Status of Policyholder Reserves at End of Year:			
	Amount held for benefits after retirement		$0.00
	Claim reserves		$0.00
	Other reserves		$0.00

3. NON EXPERIENCE RATED CONTRACTS

	Total Premiums earned	$1,813,435.30

4. COMMISSIONS AND CONSULTANT SERVICE FEES

Name Of Recipient	Amount Paid a. Base Commissions **	Amount Paid b. Other Fees/ Commissions ***	Amount Paid c. Special Programs ****
HOLMES, MURPHY AND ASSOCIATES, LLC	$248,849.02	$0.00	$19,696.00
AVANT SPECIALTY BENEFITS, LLC	$0.00	$0.00	$70,012.29

04/27/2026

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

*Based on the terms and conditions specified in the Agreement between the Contract Holder and BCBSTX.

**Base commissions paid on your contract.

***Other fees/commissions paid on your contract or policy such as consulting fees or General Agent commissions.

****Amounts based on producer's/consultant's block of business. If calculation exceeds program's defined fixed limit: the capped payment is allocated 1) between new sales and retention, based on corresponding proportions of uncapped payment (if applicable) and 2) to the account, based on account's uncapped payment as a percentage of total block uncapped payment. If block payment falls within program's fixed dollar limit and is based on a graded per employee schedule, account amount is calculated based on processing order subject to any account fixed limit. Resulting figures are combined with other special program defined payments (such as flat amount per head, percent of premium, or per account not subject to block fixed limit).

The settlement applies to the group numbers referenced on the Benefit Program Application and may include canceled group numbers if applicable.

NOTE: The above information is provided from business records of BCBSTX maintained in the ordinary course of BCBSTX's business to assist the plan administrator in complying with certain reporting requirements for Form(s) 5500. BCBSTX certifies that this information is accurate and complete to the best of its knowledge and belief.

The amounts shown in sections 4b and 4c are not typically applied as account-specific pricing adjustments to Admin Fees or Stop Loss premium.

FEIN (Federal Employer Identification Number): 36-1236610
NAIC Company Code: 70670

Employer Account Number	Parent Customer Name	Coverage Code	Claims Paid Month	Total Subscribers	Total Members	Dental	Medical-Facility	Medical-Professional	Pharmacy	Reimbursements	Value Based Care	Administration Fee	Administration Fee - Dental	Commission	Medical Rx Rebate Credit	Other Services	RX Rebate Credit	Specific Stop Loss Premium	Telehealth	Wellbeing Management	Other Services	ADPs	Total Charges
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jan-2025	2,511	5,354		$1,773,659.44	$1,186,556.35			$8,711.03	$123,462.03		$20,138.22	($6,277.50)			$152,643.69	$1,305.72	$7,658.31		$0.00	$3,267,857.29
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Feb-2025	2,494	5,340		$819,375.11	$1,090,928.44			$8,826.87	$122,635.74		$20,001.88	($6,235.00)	($0.00)		$151,610.26	$1,296.88	$7,607.06		$0.00	$2,216,047.24
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Mar-2025	2,501	5,342		$1,737,196.31	$1,267,365.42			$8,601.66	$122,978.97		$20,058.02	($6,252.50)	$0.00		$152,035.79	$1,300.52	$7,628.35		$0.00	$3,310,912.54
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Apr-2025	2,334	4,451		$1,863,364.65	$1,181,416.79		($32,753.94)	$9,044.46	$114,839.58		$18,718.68	($5,835.00)	$0.00		$141,883.86	$1,213.68	$7,123.50	($50,000.00)	$0.00	$3,249,016.26
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	May-2025	2,490	5,218		$1,454,487.05	$1,214,125.25			$9,260.27	$122,433.30		$19,969.80	($6,225.00)	$0.00		$151,367.10	$1,294.80	$7,594.50		$0.00	$2,974,307.07
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jun-2025	2,495	5,240		$1,441,644.75	$1,402,860.81		($139.39)	$9,498.24	$122,679.15		$20,009.90	($6,237.50)	$0.00		$151,671.05	$1,297.40	$7,609.75		$0.00	$3,150,894.16
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jul-2025	2,496	5,280		$1,818,551.11	$1,555,220.67		($1,226.72)	$9,067.08	$122,733.12		$20,017.92	($6,240.00)	($0.00)		$151,731.84	$1,297.92	$7,613.10		$0.00	$3,678,766.04
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Aug-2025	2,511	5,271		$2,176,583.73	$1,478,775.42			$9,097.40	$123,466.83		$20,138.22	($6,277.50)	$0.00		$152,643.69	$1,305.72	$7,658.61		$0.00	$3,963,392.12
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Sep-2025	2,545	5,333		$1,678,746.55	$1,296,736.31		($5,529.97)	$9,086.61	$125,137.65		$20,410.90	($6,362.50)	$0.00		$154,710.55	$1,323.40	$7,762.25		$0.00	$3,282,021.75
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Oct-2025	2,519	5,281		$1,855,213.15	$1,745,255.63			$10,188.63	$123,863.07		$20,202.38	($6,297.50)	$0.00		$153,130.01	$1,309.88	$7,683.19		$0.00	$3,910,548.44
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Nov-2025	2,531	5,347		$1,315,896.96	$1,212,082.90			$10,571.63	$124,449.27		$20,298.62	($6,327.50)			$153,859.49	$1,316.12	$7,719.55		$0.00	$2,839,867.04
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Dec-2025	2,523	5,292		$2,749,579.96	$1,616,600.32			$10,456.15	$124,055.91		$20,234.46	($6,307.50)			$153,373.17	$1,311.96	$7,695.15		$0.00	$4,676,999.58
TX1-090138	SOUTHERN METHODIST UNIVERS	**MD Total**					**$20,684,298.77**	**$16,247,924.31**		**($39,650.02)**	**$112,410.03**	**$1,472,734.62**		**$240,199.00**	**($74,875.00)**	**$0.00**		**$1,820,660.50**	**$15,574.00**	**$91,353.32**	**($50,000.00)**	**$0.00**	**$40,520,629.53**
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jan-2025	2,511	5,354				$1,079,488.45								($407,620.30)					$0.00	$671,868.15
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Feb-2025	2,494	5,340				$895,368.25								($405,399.96)					$0.00	$489,968.29
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Mar-2025	2,501	5,342				$1,100,778.53								($406,482.82)					$0.00	$694,295.71
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Apr-2025	2,334	4,451				$991,982.54								($383,414.68)					$0.00	$608,567.86
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	May-2025	2,490	5,218				$1,506,342.36								($404,425.80)					$0.00	$1,101,916.56
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jun-2025	2,495	5,240				$1,215,970.84								($405,237.90)					$0.00	$810,732.94
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jul-2025	2,496	5,280				$1,158,644.04								($405,670.72)					$0.00	$752,973.32
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Aug-2025	2,511	5,271				$1,714,421.26								($407,890.70)					$0.00	$1,306,530.56
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Sep-2025	2,545	5,333				$1,394,977.08								($413,358.90)					$0.00	$981,618.18
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Oct-2025	2,519	5,281				$1,738,025.11								($409,352.30)					$0.00	$1,328,672.81
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Nov-2025	2,531	5,347				$1,498,786.37								($411,085.02)					$0.00	$1,087,701.35
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Dec-2025	2,523	5,292				$1,561,888.29								($409,785.66)					$0.00	$1,152,102.63
TX1-090138	SOUTHERN METHODIST UNIVERS	**RX Total**							**$15,856,673.12**								**($4,869,724.76)**					**$0.00**	**$10,986,948.36**
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jan-2025	2,448	5,139	$207,322.28							$6,756.48									$0.00	$214,078.76
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Feb-2025	2,441	5,134	$216,971.71							$6,737.16									$0.00	$223,708.87
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Mar-2025	2,462	5,172	$197,999.35							$6,795.12									$0.00	$204,794.47
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Apr-2025	2,245	4,097	$221,671.70							$6,196.20									$0.00	$227,867.90
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	May-2025	2,439	5,008	$212,225.80							$6,731.64									$0.00	$218,957.44
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jun-2025	2,427	5,013	$213,558.45							$6,698.52									$0.00	$220,256.97
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jul-2025	2,436	5,026	$228,671.74							$6,723.36									$0.00	$235,395.10
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Aug-2025	2,414	4,989	$223,387.69							$6,662.64									$0.00	$230,050.33
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Sep-2025	2,471	5,069	$182,149.76							$6,819.96									$0.00	$188,969.72
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Oct-2025	2,473	5,069	$189,730.47							$6,825.48									$0.00	$196,555.95
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Nov-2025	2,462	5,057	$173,146.34							$6,795.12									$0.00	$179,941.46
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Dec-2025	2,451	5,029	$215,935.95							$6,764.76									$0.00	$222,700.71
TX1-090138	SOUTHERN METHODIST UNIVERS	**DN Total**				**$2,482,771.24**							**$80,506.44**									**$0.00**	**$2,563,277.68**
TX1-090138	**SOUTHERN METHODIST UNIVERSITY Total**					**$2,482,771.24**	**$20,684,298.77**	**$16,247,924.31**	**$15,856,673.12**	**($39,650.02)**	**$112,410.03**	**$1,472,734.62**	**$80,506.44**	**$240,199.00**	**($74,875.00)**	**$0.00**	**($4,869,724.76)**	**$1,820,660.50**	**$15,574.00**	**$91,353.32**	**($50,000.00)**	**$0.00**	**$54,070,855.57**