

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**2021****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2021 or fiscal plan year beginning **04/01/2021** and ending **03/31/2022**

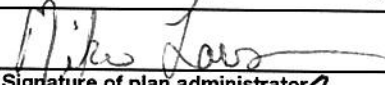
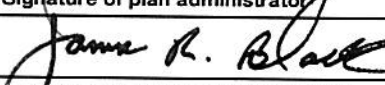
- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instr.)
- B** This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here ▶
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶

Part II Basic Plan Information - enter all requested information

1a Name of plan TEAMSTERS LOCAL UNION NO. 716 PENSION PLAN	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan 04/01/1975
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) JT BOARD OF TRUSTEES TEAMSTERS	2b Employer Identification Number (EIN) 51-0175810
	2c Plan Sponsor's telephone number 317-639-3573
6007 S. HARDING STREET	2d Business code (see instructions) 813930
INDIANAPOLIS IN 462179597	

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

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

SIGN HERE		1/12/2023	MIKE LARSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		1/12/2023	JAMES R. BLACK
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2021)
v. 210624

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor JT BOARD OF TRUSTEES TEAMSTERS 6007 S. HARDING STREET INDIANAPOLIS IN 462179597	3b Administrator's EIN 51-0175810 3c Administrator's telephone number 317-639-3573
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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
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5 Total number of participants at the beginning of the plan year	5	2,444
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)	700
a (2) Total number of active participants at the end of the plan year	6a(2)	
b Retired or separated participants receiving benefits	6b	769
c Other retired or separated participants entitled to future benefits	6c	763
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	1,532
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	769
f Total. Add lines 6d and 6e	6f	2,301
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
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	28

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

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) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input checked="" type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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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 2021 Form M-1 annual report. If the plan was not required to file the 2021 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 _____

Credits to funding standard account:			
f	Prior year credit balance, if any	9f	20,894,948
g	Employer contributions. Total from column (b) of line 3	9g	4,328,439
		Outstanding balance	
h	Amortization credits as of valuation date	9h	12,131,241
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i	1,792,773
j Full funding limitation (FFL) and credits:			
(1)	ERISA FFL (accrued liability FFL)	9j(1)	39,735,984
(2)	"RPA '94" override (90% current liability FFL)	9j(2)	98,701,645
(3)	FFL credit	9j(3)	
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	28,684,903
m	Credit balance: If line 9l is greater than line 9e, enter the difference	9m	21,173,544
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference	9n	
9o Current year's accumulated reconciliation account:			
(1)	Due to waived funding deficiency accumulated prior to the 2021 plan year	9o(1)	
(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)	
(b)	Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))	9o(2)(b)	
(3)	Total as of valuation date	9o(3)	
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.	OMB No. 1210-0110 2021 This Form is Open to Public Inspection.
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For calendar plan year 2021 or fiscal plan year beginning **04/01/2021** and ending **03/31/2022**

A Name of plan TEAMSTERS LOCAL UNION NO. 716 PENSION PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 JT BOARD OF TRUSTEES TEAMSTERS	D Employer Identification Number (EIN) 51-0175810

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): _____
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 contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer **MARTIN MARIETTA**

b EIN **31-7060001** **c** Dollar amount contributed by employer **245,271.**

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 **2022**

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) **2.00**

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

a Name of contributing employer **DWD COMPANY, LLC**

b EIN **81-4047892** **c** Dollar amount contributed by employer **276,208.**

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 **05** Day **31** Year **2022**

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): **13% OF GROSS WAGES**

a Name of contributing employer **CMG TRUCKING, INC.**

b EIN **26-3348631** **c** Dollar amount contributed by employer **467,409.**

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 **2022**

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): **13% OF GROSS WAGES**

a Name of contributing employer **D TRANSPORT**

b EIN **35-2042612** **c** Dollar amount contributed by employer **510,840.**

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 **04** Day **30** Year **2022**

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): **13% OF GROSS WAGES**

a Name of contributing employer **IRVING MATERIALS, INC.**

b EIN **35-0817664** **c** Dollar amount contributed by employer **1,227,423.**

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 **04** Day **30** Year **2022**

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) **3.70**

(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	

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) through (c)

a Enter the percentage of plan assets held as:
 Stock: 71.0 % Investment-Grade Debt: 24.0 % High-Yield Debt: .0 % Real Estate: .0 % Other: 5.0 %

b Provide the average duration of the combined investment-grade and high-yield debt:
 0-3 years 3-6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-21 years 21 years or more

c What duration measure was used to calculate line 19(b)?
 Effective duration Macaulay duration Modified duration Other (specify):

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 _____

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 1

NAME	SERVICE CODES
CHARLES SCHWAB TRUST BANK	19
CHARLES SCHWAB TRUST BANK	28
CHARLES SCHWAB TRUST BANK	51
CHARLES SCHWAB TRUST BANK	52

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER ADMINISTRATIVE EXPENSES STATEMENT 2

DESCRIPTION	AMOUNT
ADMIN. SERVICE PROVIDERS (SALARIES, FEES AND COMMISSIONS)	152,260.
TOTAL TO SCHEDULE H, LINE 2I(4)	152,260.

Paydhealth

Please find the annualized Paydhealth prescription drug plan savings range and moderate-level forecast for the next two years (rounded to the 4th digit). The information contained here, and any plan document language should be kept in confidence within the scope of the proposed. The savings range is influenced by assumptions related to medication adherence rates and attrition related to fills, expected incidence of highly compensated employees (HCEs), and our current alternate funding data. If you desire to net out the savings relative to rebate guarantees a manner to do so would be to reduce the Net Specialty Spend line by any expected rebates (e.g., Multiple Project Rebate-eligible Claims by your PBMs offered Rebate Guarantee). The analysis assumes all plan lives are not enrolled in Medicare, Medicaid, other federally sponsored plans and or an Employer Group Waiver Plan (EGWP).

(a) is the Best Case, (m) is the Base Case.

Estimated Plan Participants or beneficiaries expected to enroll in the Select Drugs & Products Program	63
Distinct select drugs and products included in analysis	27
Total Specialty drug count basis for savings estimate	436
Select Drugs and Products Program Claims (a)	342
Projected Rebate-eligible Claims under the (a) scenario. Must be confirmed with offering PBM.	198

Forecast	Current (as Provided)	paydhealth (a) at AWP less 20%	paydhealth (m) at AWP less 20%	(m) Basis		
				Year 1	Year 2	2Y Total
Gross Specialty Claims	\$5,594,869	\$5,482,972	\$5,482,972	\$6,420,000	\$7,520,000	\$13,940,000
Less Adjustment - Alternate Funding Contribution	\$0	(\$3,265,276)	(\$2,285,693)	(\$2,670,000)	(\$3,130,000)	(\$5,800,000)
Adjusted Gross Specialty Spend	\$5,594,869	\$2,217,696	\$3,197,279	\$3,750,000	\$4,390,000	\$8,140,000
Plus Program Fee	\$0	\$979,583	\$685,708	\$801,000	\$939,000	\$1,740,000
Less Estimated Manufacturer Rebates Earned	\$0	\$0	\$0	\$0	\$0	\$0
Net Specialty Program Spend	\$5,594,869	\$3,197,279	\$3,882,987	\$4,551,000	\$5,329,000	\$9,880,000
Annualized Savings compared to Current		\$2,397,591	\$1,714,883			

therapeutic class	cost basis		estimated savings (a)		estimated savings (m)	
	members	fills	fills	fills	fills	fills
IMMUNOSUPPRESSANTS	6	36	33	240,980	23	\$168,686
CNS DRUGS	7	44	25	242,989	18	\$170,093
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS	14	128	118	1,197,015	83	\$837,911
GASTROINTESTINAL	2	12	11	21,169	8	\$14,818
ANTIASTHMATICS	7	42	39	141,136	27	\$98,795
ANTINEOPLASTICS	4	20	18	198,039	13	\$138,627
UNCLASSIFIED DRUG PRODUCTS	5	50	17	280,094	12	\$196,066
ANTIARTHRITICS	5	32	30	226,444	21	\$158,511
SKIN PREPS	10	52	46	638,343	32	\$446,840
ANTIVIRALS	1	2	2	37,065	1	\$25,946
SEDATIVE/HYPNOTICS	2	18	3	42,000	2	\$29,400
total	63	436	342	3,265,276	240	\$ 2,285,693

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.	OMB No. 1210-0110 2021 This Form is Open to Public Inspection.
For calendar plan year 2021 or fiscal plan year beginning 04/01/2021 and ending 03/31/2022		
A Name of plan TEAMSTERS LOCAL UNION NO. 716 PENSION PLAN		B Three-digit plan number (PN) ► 002
C Plan sponsor's name as shown on line 2a of Form 5500 JT BOARD OF TRUSTEES TEAMSTERS		D Employer Identification Number (EIN) 51-0175810

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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(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 on page 1, 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)

SEE STATEMENT 1

CHARLES SCHWAB TRUST BANK 82-3967259
 2360 CORPORATE CIRCLE STE 400
 HENDERSON NV 89074

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 51	CUSTODIAN	483,105.	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)

UNITED ACTUARIAL 35-2156428
 11590 NORTH MERIDIAN ST., STE 610
 CARMEL IN 46032

(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	ACTUARY	44,600.	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)

PARAMOUNT CONSULTING
 5235 ASHFORD RD.
 DUBLIN OH 43017

(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	PLAN ADMINISTRATOR	33,489.	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 on page 1, 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)

SEE STATEMENT 1

ALATEK, LLC
P.O. BOX 834
CROSSVILLE

62-1782185

TN 38557

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
99	NONE	27,150.	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)

PILE CPAS

35-0865680

ONE INDIANA SQUARE, STE. 1200
INDIANAPOLIS IN 46204

(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	AUDITOR	24,250.	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)

HEALTH BENEFITS FUND
6007 S. HARDING ST.
INDIANAPOLIS

35-1074113

IN 46203

(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?
	NONE	7,579.	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"/>

**SCHEDULE H
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2021

**This Form is Open
to Public Inspection**

For calendar plan year 2021 or fiscal plan year beginning **04/01/2021** and ending **03/31/2022**

A Name of plan	B Three-digit plan number (PN) ▶	002
TEAMSTERS LOCAL UNION NO. 716 PENSION PLAN		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
JT BOARD OF TRUSTEES TEAMSTERS		
		51-0175810

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a	Total noninterest-bearing cash	1a 4,755,719	1,356,213
b	Receivables (less allowance for doubtful accounts):		
	(1) Employer contributions	1b(1) 196,293	235,469
	(2) Participant contributions	1b(2)	
	(3) Other	1b(3) 53,566	34,610
c	General investments:		
	(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)	
	(2) U.S. Government securities	1c(2) 3,159,671	1,342,892
	(3) Corporate debt instruments (other than employer securities):		
	(A) Preferred	1c(3)(A)	
	(B) All other	1c(3)(B) 18,924,711	23,203,971
	(4) Corporate stocks (other than employer securities):		
	(A) Preferred	1c(4)(A) 1,522,546	523,685
	(B) Common	1c(4)(B) 68,423,696	71,179,922
	(5) Partnership/joint venture interests	1c(5)	
	(6) Real estate (other than employer real property)	1c(6)	
	(7) Loans (other than to participants)	1c(7)	
	(8) Participant loans	1c(8)	
	(9) Value of interest in common/collective trusts	1c(9)	
	(10) Value of interest in pooled separate accounts	1c(10)	
	(11) Value of interest in master trust investment accounts	1c(11)	
	(12) Value of interest in 103-12 investment entities	1c(12)	
	(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13) 852,230	505,804
	(14) Value of funds held in insurance co. general account (unallocated contracts)	1c(14)	
	(15) Other	1c(15)	

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

Schedule H (Form 5500) 2021
v. 210624

		(a) Beginning of Year	(b) End of Year
1 d	Employer-related investments:		
	(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	97,888,432 98,382,566
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	1,458 4,207
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	1,458 4,207
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	97,886,974 98,378,359

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.

		(a) Amount	(b) Total
Income			
a	Contributions:		
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	4,328,439
	(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)	4,328,439
b	Earnings on investments:		
	(1) Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	51,845
	(C) Corporate debt instruments	2b(1)(C)	794,157
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	
	(F) Other	2b(1)(F)	101,678
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	947,680
	(2) Dividends: (A) Preferred stock	2b(2)(A)	12,615
	(B) Common stock	2b(2)(B)	1,714,642
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	12,184
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)	1,739,441
	(3) Rents	2b(3)	
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	53,132,646
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	50,778,130
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	2,354,516
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	-1,260,221
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	-1,260,221

	(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)	
c Other income	2c	
d Total income. Add all income amounts in column (b) and enter total	2d	8,109,855

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	6,904,538
(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)	6,904,538
f Corrective distributions (see instructions)	2f	
g Certain deemed distributions of participant loans (see instructions)	2g	
h Interest expense	2h	
i Administrative expenses: (1) Professional fees	2i(1)	71,395
(2) Contract administrator fees	2i(2)	
(3) Investment advisory and management fees	2i(3)	490,277
(4) Other SEE STATEMENT 2	2i(4)	152,260
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	713,932
j Total expenses. Add all expense amounts in column (b) and enter total	2j	7,618,470

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	491,385
l Transfers of assets:		
(1) To this plan	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

- 3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.
- a The attached opinion of an independent qualified public accountant for this plan is (see instructions):
 (1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse
- b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.
 (1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).
- c Enter the name and EIN of the accountant (or accounting firm) below:
 (1) Name: **PILE, CPAS** (2) EIN: **35-8865680**
- d The opinion of an independent qualified public accountant is **not attached** because:
 (1) This form is filed for a CCT, PSA, 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.
- 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 | |

	Yes	No	Amount
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		500,000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3		X	

5 a 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

5 b 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)

5 c 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 452742

SCHEDULE MB (Form 5500) <small>Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration 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.	OMB No. 1210-0110 2021 This Form is Open to Public Inspection
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For calendar plan year 2021 or fiscal plan year beginning 04/01/2021 and ending 03/31/2022

▶ **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	B Three-digit plan number (PN) ▶	002
<u>TEAMSTERS LOCAL UNION NO. 716 PENSION PLAN</u>		

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF	D Employer Identification Number (EIN)
<u>JT BOARD OF TRUSTEES TEAMSTERS</u>	<u>51-0175810</u>

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

1 a Enter the valuation date: Month <u>04</u> Day <u>01</u> Year <u>2021</u>	
b Assets	
(1) Current value of assets	1b(1) 97,886,974
(2) Actuarial value of assets for funding standard account	1b(2) 97,886,974
c (1) Accrued liability for plan using immediate gain methods	1c(1) 112,598,156
(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) 112,598,156
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) 217,002,555
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b) 3,496,448
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c) 7,863,618
(3) Expected plan disbursements for the plan year	1d(3) 7,943,040

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>01/06/2023</u>
Signature of actuary	Date
<u>ERIKA L. CREAGER, EA, MAAA</u>	<u>2007288</u>
Type or print name of actuary	Most recent enrollment number
<u>UNITED ACTUARIAL SERVICES, INC.</u>	<u>317-371-1530</u>
Firm name	Telephone number (including area code)
<u>11590 N. MERIDIAN STREET, SUITE 610</u>	
<u>CARMEL IN 46032</u>	
Address of the firm	

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	97,886,974
b "RPA '94" current liability/participant count breakdown:		
(1) For retired participants and beneficiaries receiving payment	(1) Number of participants	(2) Current liability
(2) For terminated vested participants	769	96,682,605
(3) For active participants:		
(a) Non-vested benefits		3,925,247
(b) Vested benefits		63,319,740
(c) Total active	763	67,244,987
(4) Total	2,190	217,002,555
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	45.1100 %

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
03-31-2022	4,328,439				
Totals ▶			3(b)	4,328,439	3(c)
(d) Total withdrawal liability amounts included in line 3(b) total					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	86.90 %
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?		Yes <input type="checkbox"/> No <input type="checkbox"/>
d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
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 rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here <input type="checkbox"/>	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?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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 202.00 %

	Pre-retirement			Post-retirement		
	Yes	No	<input checked="" type="checkbox"/> N/A	Yes	No	<input checked="" type="checkbox"/> N/A
b Rates specified in insurance or annuity contracts			<input checked="" type="checkbox"/> N/A			<input checked="" type="checkbox"/> N/A
c Mortality table code for valuation purposes:						
(1) Males	6c(1) A			A		
(2) Females	6c(2) A			A		
d Valuation liability interest rate	6d 7.25 %			7.25 %		
e Expense loading	6e 14.0 %		N/A			<input checked="" type="checkbox"/> N/A
f Salary scale	6f %		<input checked="" type="checkbox"/> N/A			
g Estimated investment return on actuarial value of assets for year ending on the valuation date	6g			16.8 %		
h Estimated investment return on current value of assets for year ending on the valuation date	6h			35.5 %		

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	972,728	101,159
4	-265,476	-27,608
5	-7,638,932	-1,025,841

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 (1) Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule Yes No

b (2) Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule Yes 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? Yes 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? Yes 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? Yes 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? Yes No

e If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(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 1,443,491

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) 47,737,371	5,560,111
(2) Funding waivers	9c(2)	
(3) Certain bases for which the amortization period has been extended	9c(3)	

d Interest as applicable on lines 9a, 9b, and 9c 9d 507,757

e Total charges. Add lines 9a through 9d 9e 7,511,359