

**Form 5500**Department 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**2016****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2016 or fiscal plan year beginning **09/01/2016** and ending **08/31/2017**

- 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)

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

<b>1a</b> Name of plan <b>CARPENTERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA</b>	<b>1b</b> Three-digit plan number (PN) ▶ <b>001</b>
	<b>1c</b> Effective date of plan <b>08/19/1958</b>
<b>2a</b> 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) <b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>2b</b> Employer Identification Number (EIN) <b>94-6050970</b>
	<b>2c</b> Plan Sponsor's telephone number <b>(510) 633-0333</b>
<b>265 HEGENBERGER ROAD</b>	<b>2d</b> Business code (see instructions) <b>236200</b>
<b>OAKLAND CA 94621</b>	

**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.

<b>SIGN HERE</b>			
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number) <b>VAVRINEK, TRINE, DAY &amp; CO., LLP 1900 S. NORFOLK STREET SUITE 225 SAN MATEO CA 94402</b>			Preparer's telephone number <b>650-522-3400</b>

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

Form 5500 (2016)  
v. 160205

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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<b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: <b>a</b> Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN
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<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	4 6 6 8 2
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	1 9 8 6 5
<b>a (2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	2 1 9 3 5
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b>	1 4 8 6 3
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	8 7 8 4
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....	<b>6d</b>	4 5 5 8 2
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>	3 4 7 8
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....	<b>6f</b>	4 9 0 6 0
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g</b>	
<b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	1 0 7 6

**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:

<b>9a</b> Plan funding arrangement (check all that apply) (1) <input checked="" 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	<b>9b</b> 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)  **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

**b General Schedules**

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

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

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**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.

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**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 2016 Form M-1 annual report. If the plan was not required to file the 2016 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 \_\_\_\_\_

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<p align="center"><b>SCHEDULE A (Form 5500)</b></p> <p align="center">Department of the Treasury Internal Revenue Service</p> <hr/> <p align="center">Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p align="center">▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p align="center">OMB No. 1210-0110</p> <hr/> <p align="center"><b>2016</b></p> <hr/> <p align="center"><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2016 or fiscal plan year beginning **09/01/2016** and ending **08/31/2017**

<b>A</b> Name of plan <b>CARPENTERS PENSION TRUST FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>001</b>
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<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6050970</b>
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**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier  
**THE UNION LABOR LIFE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	GA02011	49060	09/01/2016	08/31/2017

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

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
41435	0

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

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**ULLICO INVESTMENT COMPANY**  
**8403 COLEVILLE ROAD**  
**SILVER SPRING MD 20910**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
41435			3

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b>
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....	<b>5</b>	58259006

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier .....

**c** Premiums due but unpaid at the end of the year .....

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs ▶

**e** Type of contract: (1)  individual policies      (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

**a** Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
 (3)  guaranteed investment      (4)  other ▶

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

- |                                   |  |                                   |                      |                                   |                           |                                   |                    |
|-----------------------------------|--|-----------------------------------|----------------------|-----------------------------------|---------------------------|-----------------------------------|--------------------|
| <b>a</b> <input type="checkbox"/> | Health (other than dental or vision)         | <b>b</b> <input type="checkbox"/> | Dental               | <b>c</b> <input type="checkbox"/> | Vision                    | <b>d</b> <input type="checkbox"/> | Life insurance     |
| <b>e</b> <input type="checkbox"/> | Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> | Long-term disability | <b>g</b> <input type="checkbox"/> | Supplemental unemployment | <b>h</b> <input type="checkbox"/> | Prescription drug  |
| <b>i</b> <input type="checkbox"/> | Stop loss (large deductible)                 | <b>j</b> <input type="checkbox"/> | HMO contract         | <b>k</b> <input type="checkbox"/> | PPO contract              | <b>l</b> <input type="checkbox"/> | Indemnity contract |
| <b>m</b> <input type="checkbox"/> | Other (specify) ▶                            |                                   |                      |                                   |                           |                                   |                    |

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>		
	<b>9a(2)</b>		
	<b>9a(3)</b>		
	<b>9a(4)</b>		
<b>b</b> Benefit charges: (1) Claims paid .....	<b>9b(1)</b>		
	<b>9b(2)</b>		
	<b>9b(3)</b>		
	<b>9b(4)</b>		
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --	<b>9c(1)(A)</b>		
	<b>9c(1)(B)</b>		
	<b>9c(1)(C)</b>		
	<b>9c(1)(D)</b>		
	<b>9c(1)(E)</b>		
	<b>9c(1)(F)</b>		
	<b>9c(1)(G)</b>		
	<b>9c(1)(H)</b>		
	<b>9c(2)</b>		
	<b>9c(2)</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	<b>9d(1)</b>		
	<b>9d(2)</b>		
	<b>9d(3)</b>		
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line <b>9c(2)</b> .) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

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

Specify nature of costs

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... Yes  No

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

<b>SCHEDULE C (Form 5500)</b> Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	<b>Service Provider Information</b> This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). <p style="text-align: center;">▶ <b>File as an attachment to Form 5500.</b></p>	OMB No. 1210-0110 <hr/> <b>2016</b> <hr/> <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2016 or fiscal plan year beginning <b>09/01/2016</b> and ending <b>08/31/2017</b>	
<b>A</b> Name of plan <b>CARPENTERS PENSION TRUST FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6050970</b>

**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

**ENTRUST CAPITAL** **90-0644478**

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

**NEWTOWER TRUST COMPANY** **20-1641876**

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

**CORBIN CAPITAL PARTNERS LP** **30-0299433**

(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 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)

C.F.A.O. 94-1557079

(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	SALARIED ADMINISTRATOR	4250365.	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)

WASHINGTON CAPITAL MANAGEMENT 91-1163419

(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	1793211.	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)

BLACKROCK 13-3806691

(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	1555010.	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)						
ROTHSCHILD ASSET MANAGEMENT <span style="float: right;">13-2544634</span>						
(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	874092.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
FRED ALGER MANAGEMENT INC. <span style="float: right;">13-2510833</span>						
(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?
51 28	NONE	783002.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	41561.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
POST ADVISORY GROUP <span style="float: right;">95-4818300</span>						
(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	746384.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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)

TIMESQUARE CAPITAL MANAGEMENT 20-1665304

(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	704037.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

PRINCIPAL GLOBAL 42-1479618

(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	571957.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FISHER INVESTMENTS 20-2480800

(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 31	NONE	567891.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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)						
<b>WEDGE CAPITAL MANAGEMENT</b> <span style="float: right;"><b>56-1557450</b></span>						
(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?
51 68	NONE	460922.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
<b>RBC GLOBAL ASSET MGMT</b> <span style="float: right;"><b>41-1460668</b></span>						
(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 68	NONE	390066.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
<b>UNION LABOR LIFE INSURANCE COMPANY</b> <span style="float: right;"><b>13-1423090</b></span>						
(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	384469.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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)

STONE PINE ACCOUNTING SERVICES, LLC  
4643 S ULSTER STREET  
DENVER CA 80237

(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 52	NONE	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	250000.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

MCMORGAN & CO. 52-2334338

(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	236049.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AMERICAN REALTY  
4 EMBARCADERO CENTER, SUITE 1400  
SAN FRANCISCO CA 94111

(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	216784.	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)						
BANK OF NEW YORK <span style="float: right;">95-3571558</span>						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 51	NONE	194881.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
SEGAL COMPANY <span style="float: right;">94-1503999</span>						
(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	185994.	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)						
GERDING EDLEN 1477 NW EVERETT ST. PORTLAND <span style="float: right;">OR 97209</span>						
(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	184647.	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)

IPS 58-1645832

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 51	NONE	167108.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

KRAW LAW GROUP 77-0171216

(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	127785.	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)

QUEST 98-0880854

(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	127282.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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)

**HAMILTON LANE ADVISORS, LLC** **23-2962336**

<b>(b)</b> Service Code(s)	<b>(c)</b> Relationship to employer, employee organization, or person known to be a party-in-interest	<b>(d)</b> Enter direct compensation paid by the plan. If none, enter -0-.	<b>(e)</b> Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	<b>(f)</b> Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	<b>(g)</b> Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	<b>(h)</b> Did the service provider give you a formula instead of an amount or estimated amount?
28 52 99	NONE	121133.	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)

**WEINBERG, ROGER AND ROSENFELD** **94-2458080**

<b>(b)</b> Service Code(s)	<b>(c)</b> Relationship to employer, employee organization, or person known to be a party-in-interest	<b>(d)</b> Enter direct compensation paid by the plan. If none, enter -0-.	<b>(e)</b> Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	<b>(f)</b> Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	<b>(g)</b> Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	<b>(h)</b> Did the service provider give you a formula instead of an amount or estimated amount?
29 51	NONE	114318.	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)

**US REIF ( INTERCONTINENTAL )** **11-3786306**

<b>(b)</b> Service Code(s)	<b>(c)</b> Relationship to employer, employee organization, or person known to be a party-in-interest	<b>(d)</b> Enter direct compensation paid by the plan. If none, enter -0-.	<b>(e)</b> Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	<b>(f)</b> Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	<b>(g)</b> Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	<b>(h)</b> Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	89360.	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)						
HEMING MORSE <span style="float: right;">30-0702322</span>						
(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	65204.	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)						
SEGAL SELECT INSURANCE SERVICES <span style="float: right;">46-0619194</span>						
(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?
53 23	NONE	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	42556.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
AMALGAMATED BANK (LONGVIEW) <span style="float: right;">13-4920330</span>						
(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	21062.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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
IPS	27 51	0.
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation  VARIOUS 58-1645832	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  SEE STATEMENT 1	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
TIMESQUARE CAPITAL MANAGEMENT	68 28	0.
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation  VARIOUS 7 TIMES SQUARE, 42ND FLOOR NEW YORK NY 10036	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  SEE STATEMENT 2	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
STONE PINE ACCOUNTING SERVICES, LLC	52 28	250000.
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation  HAMILTON LANE ADVISORS, LLC 23-2962336	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  MANAGEMENT FEES	

**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
FRED ALGER MANAGEMENT INC.	68 28	9237.
(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.	
J.P. MORGAN CHASE SECURITIES 360 PARK AVE SOUTH NEW YORK NY 10010	SOFT DOLLAR COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FRED ALGER MANAGEMENT INC.	68 28	12647.
(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.	
WEEDEN & CO. 360 PARK AVE SOUTH NEW YORK NY 10010	SOFT DOLLAR COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FRED ALGER MANAGEMENT INC.	68 28	5953.
(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.	
JONES TRADING 220 E 42ND ST NEW YORK NY 10017	SOFT DOLLAR COMMISSIONS	

**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
FRED ALGER MANAGEMENT INC.	28 68	5715.
(d) Enter name and EIN (address) of source of indirect compensation  MERRILL LYNCH & CO 250 VESEY ST NEW YORK NY 10281	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  SOFT DOLLAR COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
FRED ALGER MANAGEMENT INC.	28 68	5480.
(d) Enter name and EIN (address) of source of indirect compensation  RAFFERTY CAPITAL MARKETS 865 S FIGUEROA ST LOS ANGELES CA 90017	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  SOFT DOLLAR COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
SEGAL SELECT INSURANCE SERVICES	53 23	42556.
(d) Enter name and EIN (address) of source of indirect compensation  CHUBB 13-1963496	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  INSURANCE BROKERAGE COMMISSIONS AND FEES	

**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
27-3350609 CHEVY CHASE TRUST CO - AFL CIO	28 EQU 52	SERVICE PROVIDER FAILED TO RESPOND TO INDIRECT COMPENSATION QUESTIONNAIRE

(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

<b>SCHEDULE D</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration	<b>DFE/Participating Plan Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2016</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2016 or fiscal plan year beginning **09/01/2016** and ending **08/31/2017**

<b>A</b> Name of plan <b>CARPENTERS PENSION TRUST FUND</b>	<b>B</b> Three-digit plan number (PN) ►	<b>001</b>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6050970</b>	

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

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **SEPARATE ACCOUNT J**

**b** Name of sponsor of entity listed in (a): **THE UNION LABOR LIFE INSURANCE COMPANY**

<b>c</b> EIN-PN <b>13-1423090 203</b>	<b>d</b> Entity code <b>P</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>58259006.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **MULTI-EMPLOYER PROPERTY TRUST**

**b** Name of sponsor of entity listed in (a): **NEWTOWER TRUST COMPANY**

<b>c</b> EIN-PN <b>52-6218800 001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>140918070.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **WASHINGTON CAPITAL JOINT MASTER TRU**

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

<b>c</b> EIN-PN <b>91-1163419 001</b>	<b>d</b> Entity code <b>E</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>159694211.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **EB TEMPORARY INVESTMENT**

**b** Name of sponsor of entity listed in (a): **THE BANK OF NY MELLON**

<b>c</b> EIN-PN <b>25-6078093 023</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>105073008.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **BLACKROCK GLOBAL ALLOCATION COLLECT**

**b** Name of sponsor of entity listed in (a): **BLACKROCK INSTITUTIONAL TRUST COMPANY NA**

<b>c</b> EIN-PN <b>46-0563260 001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>169131036.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **FISHER INVESTMENTS COLLECTIVE TRUST**

**b** Name of sponsor of entity listed in (a): **SEI TRUST COMPANY**

<b>c</b> EIN-PN <b>45-5393186 058</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>105935808.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **LONGVIEW ULTRA 1 CONSTRUCTION LOAN**

**b** Name of sponsor of entity listed in (a): **AMALGAMATED BANK**

<b>c</b> EIN-PN <b>20-8434730 006</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>2213148.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AFL-CIO EQUITY INDEX FUND**

**b** Name of sponsor of entity listed in (a): **CHEVY CHASE TRUST COMPANY**

<b>c</b> EIN-PN <b>27-3350609 010</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	<b>207378405.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	
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<b>Part II</b>	<b>Information on Participating Plans (to be completed by DFEs)</b> (Complete as many entries as needed to report all participating plans)
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<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN

<b>SCHEDULE H (Form 5500)</b>  Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Financial Information</b>  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).  <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2016</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2016 or fiscal plan year beginning <b>09/01/2016</b> and ending <b>08/31/2017</b>	
<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) ► <b>001</b>
<b>CARPENTERS PENSION TRUST FUND</b>	
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)
<b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>94-6050970</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**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.

<b>Assets</b>	<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b> 561186	14769822
<b>b</b> Receivables (less allowance for doubtful accounts):		
<b>(1)</b> Employer contributions .....	<b>1b(1)</b> 29669964	33138026
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>	
<b>(3)</b> Other <b>SEE STATEMENT 3</b> .....	<b>1b(3)</b> 110728001	116269377
<b>c</b> General investments:		
<b>(1)</b> Interest-bearing cash (incl. money market accounts & certificates of deposit) ...	<b>1c(1)</b>	
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b> 100521981	84906579
<b>(3)</b> Corporate debt instruments (other than employer securities):		
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b> 51482143	63670693
<b>(B)</b> All other .....	<b>1c(3)(B)</b> 184546879	291622347
<b>(4)</b> Corporate stocks (other than employer securities):		
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>	
<b>(B)</b> Common .....	<b>1c(4)(B)</b> 805035023	919789463
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b> 293298962	310610895
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b> 18040000	18468569
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b> 14982368	546354
<b>(8)</b> Participant loans .....	<b>1c(8)</b>	
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b> 623175867	730649475
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b> 56397337	58259006
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>	
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b> 169549989	159694211
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	
<b>(14)</b> Value of funds held in insurance co. general account (unallocated contracts) ...	<b>1c(14)</b>	
<b>(15)</b> Other <b>SEE STATEMENT 4</b> .....	<b>1c(15)</b> 728230668	753010837

		(a) Beginning of Year	(b) End of Year
<b>1 d</b>	Employer-related investments:		
	(1) Employer securities .....	<b>1d(1)</b>	
	(2) Employer real property .....	<b>1d(2)</b>	
<b>e</b>	Buildings and other property used in plan operation .....	<b>1e</b>	
<b>f</b>	Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	3186220368 3555405654
<b>Liabilities</b>			
<b>g</b>	Benefit claims payable .....	<b>1g</b>	
<b>h</b>	Operating payables .....	<b>1h</b>	1921069 1505956
<b>i</b>	Acquisition indebtedness .....	<b>1i</b>	
<b>j</b>	Other liabilities <b>SEE STATEMENT 5</b> .....	<b>1j</b>	111366147 114174465
<b>k</b>	Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	113287216 115680421
<b>Net Assets</b>			
<b>l</b>	Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	3072933152 3439725233

**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
<b>Income</b>			
<b>a</b>	<b>Contributions:</b>		
	(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>	288579011
	<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	
	<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>	
	(2) Noncash contributions .....	<b>2a(2)</b>	
	(3) Total contributions. Add lines <b>2a(1)(A), (B), (C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>	288579011
<b>b</b>	<b>Earnings on investments:</b>		
	(1) Interest:		
	<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>	
	<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>	1877483
	<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>	13315448
	<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>	
	<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>	
	<b>(F)</b> Other .....	<b>2b(1)(F)</b>	9701320
	<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>	24894251
	(2) Dividends: <b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>	
	<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>	14514931
	<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>	
	<b>(D)</b> Total dividends. Add lines <b>2b(2)(A), (B), and (C)</b> .....	<b>2b(2)(D)</b>	14514931
	(3) Rents .....	<b>2b(3)</b>	2311804
	(4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds ...	<b>2b(4)(A)</b>	1317698454
	<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>	1252841069
	<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result ...	<b>2b(4)(C)</b>	64857385
	(5) Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate ...	<b>2b(5)(A)</b>	428569
	<b>(B)</b> Other .....	<b>2b(5)(B)</b>	119741775
	<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>	120170344

	(a) Amount	(b) Total
<b>(6)</b> Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>	70132287
<b>(7)</b> Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>	5424958
<b>(8)</b> Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>	
<b>(9)</b> Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>	20144222
<b>(10)</b> Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>	
<b>c</b> Other income <b>SEE STATEMENT 6</b> .....	<b>2c</b>	748156
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>	611777349

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:		
<b>(1)</b> Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	227191644
<b>(2)</b> To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	
<b>(3)</b> Other .....	<b>2e(3)</b>	
<b>(4)</b> Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>	227191644
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>	
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>	
<b>h</b> Interest expense .....	<b>2h</b>	
<b>i</b> Administrative expenses: <b>(1)</b> Professional fees .....	<b>2i(1)</b>	495868
<b>(2)</b> Contract administrator fees .....	<b>2i(2)</b>	4250365
<b>(3)</b> Investment advisory and management fees .....	<b>2i(3)</b>	10195759
<b>(4)</b> Other <b>SEE STATEMENT 7</b> .....	<b>2i(4)</b>	2851632
<b>(5)</b> Total administrative expenses. Add lines <b>2i(1)</b> through <b>(4)</b> .....	<b>2i(5)</b>	17793624
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>	244985268

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>	366792081
<b>l</b> Transfers of assets:		
<b>(1)</b> To this plan .....	<b>2l(1)</b>	
<b>(2)</b> From this plan .....	<b>2l(2)</b>	

**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)**  Unqualified **(2)**  Qualified **(3)**  Disclaimer **(4)**  Adverse

**b** Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)?  Yes  No

**c** Enter the name and EIN of the accountant (or accounting firm) below:  
**(1)** Name: **VAVRINEK, TRINE, DAY & CO., LLP** **(2)** EIN: **30-0702322**

**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
<b>a</b> 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>b</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	

	Yes	No	Amount
<b>c</b> 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.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>d</b> 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.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>e</b> Was this plan covered by a fidelity bond?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	15000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>g</b> 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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>h</b> 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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<b>j</b> 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.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>n</b> 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>o</b> Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	<input type="checkbox"/>	<input type="checkbox"/>	

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

**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** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)?  Yes  No  Not determined  
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4050375 . (See instr.)

**Part V Trust Information**

<b>6a</b> Name of trust	<b>6b</b> Trust's EIN
<b>6c</b> Name of trustee or custodian	<b>6d</b> Trustee's or custodian's telephone number

<b>SCHEDULE MB (Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information</b>  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).  <b>► File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2016</b>  <b>This Form is Open to Public Inspection</b>
--	--	---

For calendar plan year 2016 or fiscal plan year beginning 09/01/2016, and ending 08/31/2017,

► **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.

<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) ►	001
CARPENTERS PENSION TRUST FUND		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF	<b>D</b> Employer Identification Number (EIN)	
BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO		94-6050970

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

**1 a** Enter the valuation date: Month 09 Day 01 Year 2016

<b>b</b> Assets		
(1) Current value of assets .....	<b>1b(1)</b>	3072933152
(2) Actuarial value of assets for funding standard account .....	<b>1b(2)</b>	3244749584
<b>c</b> (1) Accrued liability for plan using immediate gain methods .....	<b>1c(1)</b>	4409199516
(2) Information for plans using spread gain methods:		
(a) Unfunded liability for methods with bases .....	<b>1c(2)(a)</b>	
(b) Accrued liability under entry age normal method .....	<b>1c(2)(b)</b>	
(c) Normal cost under entry age normal method .....	<b>1c(2)(c)</b>	
(3) Accrued liability under unit credit cost method .....	<b>1c(3)</b>	4409199516
<b>d</b> Information on current liabilities of the plan:		
(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	<b>1d(1)</b>	
(2) "RPA '94" information:		
(a) Current liability .....	<b>1d(2)(a)</b>	8375941859
(b) Expected increase in current liability due to benefits accruing during the plan year .....	<b>1d(2)(b)</b>	331452407
(c) Expected release from "RPA '94" current liability for the plan year .....	<b>1d(2)(c)</b>	246369648
(3) Expected plan disbursements for the plan year .....	<b>1d(3)</b>	252869648

**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.

<b>SIGN HERE</b>	
Signature of actuary	05/14/2018
PAUL C. POON, ASA, MAAA, EA	Date
Type or print name of actuary	1706069
SEGAL CONSULTING	Most recent enrollment number
Firm name	415-263-8200
100 MONTGOMERY STREET, SUITE 500	Telephone number (including area code)
SAN FRANCISCO CA 94104-4308	
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:

<b>a</b> Current value of assets (see instructions)	<b>2a</b>	3072933152
<b>b</b> "RPA '94" current liability/participant count breakdown:	<b>(1)</b> Number of participants	<b>(2)</b> Current liability
<b>(1)</b> For retired participants and beneficiaries receiving payment .....	18087	2975008777
<b>(2)</b> For terminated vested participants .....	8788	1273359756
<b>(3)</b> For active participants:		
<b>(a)</b> Non-vested benefits .....		684703066
<b>(b)</b> Vested benefits .....		3442870260
<b>(c)</b> Total active .....	19134	4127573326
<b>(4)</b> Total .....	46009	8375941859
<b>c</b> If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage .....	<b>2c</b>	36.6900 %

**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
	288969394	0			
<b>Totals ▶</b>			<b>3(b)</b>	288969394	<b>3(c)</b>
					0

**4** Information on plan status:

<b>a</b> Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)) .....	<b>4a</b>	73.60 %
<b>b</b> Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If code is "N," go to line 5 .....	<b>4b</b>	C
<b>c</b> Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>d</b> If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>e</b> If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date .....	<b>4e</b>	
<b>f</b> 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 .....	<b>4f</b>	2025

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

- |  |  |  |   |
|--|--|--|---|
| <b>a</b> <input type="checkbox"/> Attained age normal      | <b>b</b> <input type="checkbox"/> Entry age normal         | <b>c</b> <input checked="" type="checkbox"/> Accrued benefit (unit credit) | <b>d</b> <input type="checkbox"/> Aggregate |
| <b>e</b> <input type="checkbox"/> Frozen initial liability | <b>f</b> <input type="checkbox"/> Individual level premium | <b>g</b> <input type="checkbox"/> Individual aggregate                     | <b>h</b> <input type="checkbox"/> Shortfall |
| <b>i</b> <input type="checkbox"/> Other (specify):         |  |  |   |

<b>j</b> If box h is checked, enter period of use of shortfall method .....	<b>5j</b>	
<b>k</b> Has a change been made in funding method for this plan year? .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>l</b> If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>m</b> 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 .....	<b>5m</b>	



<b>6 Checklist of certain actuarial assumptions:</b>									
<b>a</b>	Interest rate for "RPA '94" current liability .....							<b>6a</b>	3.11 %
		Pre-retirement			Post-retirement				
<b>b</b>	Rates specified in insurance or annuity contracts .....	<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		
<b>c</b>	Mortality table code for valuation purposes:								
	(1) Males .....	A			A				
	(2) Females .....	A			A				
<b>d</b>	Valuation liability interest rate .....	7.50 %			7.50 %				
<b>e</b>	Expense loading .....	5.0 %			N/A		<input checked="" type="checkbox"/> N/A		
<b>f</b>	Salary scale .....	<input checked="" type="checkbox"/> N/A							
<b>g</b>	Estimated investment return on actuarial value of assets for year ending on the valuation date .....				<b>6g</b>		5.6 %		
<b>h</b>	Estimated investment return on current value of assets for year ending on the valuation date .....				<b>6h</b>		5.5 %		

<b>7 New amortization bases established in the current plan year:</b>		
(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	84954768	8952829
4	37624961	3965049
5	-681903898	-92412839

<b>8 Miscellaneous information:</b>	
<b>a</b> 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 .....	<b>8a</b>
<b>b (1)</b> Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>b (2)</b> Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule .....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>c</b> 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
<b>d</b> 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 ...	<b>8d(2)</b>
(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)) .....	<b>8d(4)</b>
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension .....	<b>8d(5)</b>
(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
<b>e</b> 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) .....	<b>8e</b>

<b>9 Funding standard account statement for this plan year:</b>		
<b>Charges to funding standard account:</b>		
<b>a</b> Prior year funding deficiency, if any .....	<b>9a</b>	509651066
<b>b</b> Employer's normal cost for plan year as of valuation date .....	<b>9b</b>	130276382
<b>c</b> 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 .....	<b>9c(1)</b>	1855855481
(2) Funding waivers .....	<b>9c(2)</b>	0
(3) Certain bases for which the amortization period has been extended .....	<b>9c(3)</b>	0
<b>d</b> Interest as applicable on lines 9a, 9b, and 9c .....	<b>9d</b>	70820545
<b>e</b> Total charges. Add lines 9a through 9d .....	<b>9e</b>	1015094474

**Credits to funding standard account:**

<b>f</b>	Prior year credit balance, if any .....	<b>9f</b>	0	
<b>g</b>	Employer contributions. Total from column (b) of line 3 .....	<b>9g</b>	288969394	
			Outstanding balance	
<b>h</b>	Amortization credits as of valuation date .....	<b>9h</b>	1201056615	150035326
<b>i</b>	Interest as applicable to end of plan year on lines 9f, 9g, and 9h .....	<b>9i</b>		22089001
<b>j</b>	Full funding limitation (FFL) and credits:			
	(1) ERISA FFL (accrued liability FFL) .....	<b>9j(1)</b>	1576533452	
	(2) "RPA '94" override (90% current liability FFL) .....	<b>9j(2)</b>	4629417406	
	(3) FFL credit .....	<b>9j(3)</b>		0
<b>k</b>	(1) Waived funding deficiency .....	<b>9k(1)</b>		0
	(2) Other credits .....	<b>9k(2)</b>		0
<b>l</b>	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2) .....	<b>9l</b>		461093721
<b>m</b>	Credit balance: If line 9l is greater than line 9e, enter the difference .....	<b>9m</b>		
<b>n</b>	Funding deficiency: If line 9e is greater than line 9l, enter the difference .....	<b>9n</b>		554000753
<b>9o</b>	Current year's accumulated reconciliation account:			
	(1) Due to waived funding deficiency accumulated prior to the 2016 plan year .....	<b>9o(1)</b>		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 .....	<b>9o(2)(a)</b>		0
	(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)) .....	<b>9o(2)(b)</b>		0
	(3) Total as of valuation date .....	<b>9o(3)</b>		0
<b>10</b>	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.) .....	<b>10</b>		554000753
<b>11</b>	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

**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.**

For calendar plan year 2016 or fiscal plan year beginning **09/01/2016** and ending **08/31/2017**

<b>A</b> Name of plan <b>CARPENTERS PENSION TRUST FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, CARPENTERS PENSION TRUST FUND FO</b>	<b>D</b> Employer Identification Number (EIN)	<b>94-6050970</b>

**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** **6**

**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.**

<b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....	<b>6a</b>	
<b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>6b</b>	
<b>c</b> 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) .....	<b>6c</b>	

**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 \_\_\_\_\_

**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): \_\_\_\_\_

**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): \_\_\_\_\_

**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 participants on whose behalf no contributions were made by an employer as an employer of the participant for:

<b>a</b> The current year .....	<b>14a</b>	878
<b>b</b> The plan year immediately preceding the current plan year .....	<b>14b</b>	891
<b>c</b> The second preceding plan year .....	<b>14c</b>	841

**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:

<b>a</b> The corresponding number for the plan year immediately preceding the current plan year .....	<b>15a</b>	1.01
<b>b</b> The corresponding number for the second preceding plan year .....	<b>15b</b>	.96

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

<b>a</b> Enter the number of employers who withdrew during the preceding plan year .....	<b>16a</b>	0
<b>b</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 .....	<b>16b</b>	

**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: 37.0 % Investment-Grade Debt: 7.0 % High-Yield Debt: 7.0 % Real Estate: .0 % Other: 49.0 %

**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):

**Part VII IRS Compliance Questions**

**20a** Is the plan a 401(k) plan? If "No," skip b  Yes  No

**20b** How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:  Design-based safe harbor  "Prior year" ADP test  "Current year" ADP test  N/A

**21a** What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:  Ratio percentage test  Average benefit test  N/A

**21b** Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?  Yes  No

**22a** If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter \_\_\_\_\_ and the serial number \_\_\_\_\_

**22b** If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter \_\_\_\_\_

ERISA PENSION INVESTMENT CONFERENCE ("EPIC") HOSTED BY IPS; THE AMOUNT OF  
COMPENSATION RECEIVED BY IPS WAS EQUAL TO THE  
REGISTRATION FEES PAID BY ATTENDEES MINUS THE COST OF HOSTING THE EVENT.

SOFT DOLLAR CREDITS ARE ESTABLISHED BY APPLYING A FORMULA OF 0.625 TIMES THE AMOUNT OF COMMISSIONS PAID TO BROKERS

SCHEDULE H	OTHER RECEIVABLES	STATEMENT	3
DESCRIPTION		BEGINNING	ENDING
OTHER RECEIVABLES		110728001.	116269377.
TOTAL TO SCHEDULE H, LINE 1B(3)		110728001.	116269377.

SCHEDULE H	OTHER GENERAL INVESTMENTS	STATEMENT	4
DESCRIPTION		BEGINNING	ENDING
OTHER GENERAL INVESTMENTS		728230668.	753010837.
TOTAL TO SCHEDULE H, LINE 1C(15)		728230668.	753010837.

SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT	5
DESCRIPTION		BEGINNING	ENDING
OTHER LIABILITIES		111366147.	114174465.
TOTAL TO SCHEDULE H, LINE 1J		111366147.	114174465.

SCHEDULE H	OTHER INCOME	STATEMENT	6
DESCRIPTION			AMOUNT
OTHER INCOME			748156.
TOTAL TO SCHEDULE H, LINE 2C			748156.



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SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT	7
<u>DESCRIPTION</u>		<u>AMOUNT</u>	
OTHER ADMINISTRATIVE EXPENSES		2851632.	
TOTAL TO SCHEDULE H, LINE 2I(4)		2851632.	

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