

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning _____ and ending _____

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

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 the DFVC program

D Check box if filing under: Form 5558 automatic extension special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND	1b Three-digit plan number (PN) ▶	001
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) TRUSTEES OF OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND 6525 CENTURION DRIVE LANSING MI 48917	1c Effective date of plan 01/01/1972	2b Employer Identification Number (EIN) 38-6222545
	2c Plan Sponsor's telephone number 517-321-7502	2d Business code (see instructions) 238100

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

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

SIGN HERE		8/6/2025	Celenn Bukoski - Chairman
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		8/6/2025	Michael Stanfield - Secretary
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN																				
	3c Administrator's telephone number																				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																				
5 Total number of participants at the beginning of the plan year	<table border="1"> <tr> <td style="width: 50px;">5</td> <td style="text-align: right;">1621</td> </tr> </table>	5	1621																		
5	1621																				
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	<table border="1"> <tr> <td style="width: 50px;">6a(1)</td> <td style="text-align: right;">548</td> </tr> <tr> <td>6a(2)</td> <td style="text-align: right;">426</td> </tr> <tr> <td>6b</td> <td style="text-align: right;">412</td> </tr> <tr> <td>6c</td> <td style="text-align: right;">570</td> </tr> <tr> <td>6d</td> <td style="text-align: right;">1408</td> </tr> <tr> <td>6e</td> <td style="text-align: right;">110</td> </tr> <tr> <td>6f</td> <td style="text-align: right;">1518</td> </tr> <tr> <td>6g(1)</td> <td></td> </tr> <tr> <td>6g(2)</td> <td></td> </tr> <tr> <td>6h</td> <td></td> </tr> </table>	6a(1)	548	6a(2)	426	6b	412	6c	570	6d	1408	6e	110	6f	1518	6g(1)		6g(2)		6h	
6a(1)	548																				
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6d	1408																				
6e	110																				
6f	1518																				
6g(1)																					
6g(2)																					
6h																					
a(1) Total number of active participants at the beginning of the plan year	<table border="1"> <tr> <td style="width: 50px;">6a(1)</td> <td style="text-align: right;">548</td> </tr> </table>	6a(1)	548																		
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a(2) Total number of active participants at the end of the plan year	<table border="1"> <tr> <td style="width: 50px;">6a(2)</td> <td style="text-align: right;">426</td> </tr> </table>	6a(2)	426																		
6a(2)	426																				
b Retired or separated participants receiving benefits	<table border="1"> <tr> <td style="width: 50px;">6b</td> <td style="text-align: right;">412</td> </tr> </table>	6b	412																		
6b	412																				
c Other retired or separated participants entitled to future benefits	<table border="1"> <tr> <td style="width: 50px;">6c</td> <td style="text-align: right;">570</td> </tr> </table>	6c	570																		
6c	570																				
d Subtotal. Add lines 6a(2) , 6b , and 6c .	<table border="1"> <tr> <td style="width: 50px;">6d</td> <td style="text-align: right;">1408</td> </tr> </table>	6d	1408																		
6d	1408																				
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	<table border="1"> <tr> <td style="width: 50px;">6e</td> <td style="text-align: right;">110</td> </tr> </table>	6e	110																		
6e	110																				
f Total. Add lines 6d and 6e .	<table border="1"> <tr> <td style="width: 50px;">6f</td> <td style="text-align: right;">1518</td> </tr> </table>	6f	1518																		
6f	1518																				
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<table border="1"> <tr> <td style="width: 50px;">6g(1)</td> <td></td> </tr> </table>	6g(1)																			
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g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<table border="1"> <tr> <td style="width: 50px;">6g(2)</td> <td></td> </tr> </table>	6g(2)																			
6g(2)																					
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<table border="1"> <tr> <td style="width: 50px;">6h</td> <td></td> </tr> </table>	6h																			
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1"> <tr> <td style="width: 50px;">7</td> <td style="text-align: right;">54</td> </tr> </table>	7	54																		
7	54																				

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:

4H

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

a Pension Schedules

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

b General Schedules

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

Form **5558**
(Rev. January 2025)Department of the Treasury
Internal Revenue Service**Application for Extension of Time
To File Certain Employee Plan Returns**Go to www.irs.gov/Form5558 for the latest information.

OMB No. 1545-1610

File With IRS Only**Part I Identification**

A Name of filer, plan administrator, or plan sponsor (see instructions) TRUSTEES OF OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND	B Employer identification number (EIN) 38-6222545
Number, street, and room or suite no. (If a P.O. box, see instructions.) 6525 CENTURION DRIVE	
City or town, state, and ZIP code LANSING MI 48917	
C Name of plan OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND	D Three-digit plan number (PN) 001
E Plan year end date 12/31/2024	

Part II Extension of Time to File Form 5500 Series and/or Form 8955-SSA

- 1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, item C, above.
- 2 I request an extension of time until 10/15/25 to file Form 5500 series. See instructions.
- 3 I request an extension of time until 10/15/25 to file Form 8955-SSA. See instructions.

The application is **automatically approved** to the date shown on line 2 and/or line 3 (above) if **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.

For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Form **5558** (Rev. 1-2025)

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

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

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

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

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

Receipt Confirmation Code _____

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). u File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning		and ending
A Name of plan	B Three-digit plan number (PN) u	001
OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
TRUSTEES OF OUTSTATE MICHIGAN	** - *** 2545	

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

**BAIRD
P.O. BOX 0672

MILWAUKEE WI 53201-0672**

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

**MCMORGAN INFRASTRUCTURE FUND. LP
ONE FRONT STREET, STE 500

SAN FRANCISCO CA 94111**

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

**IFM GLOBAL INFRASTRUCTURE FUND
114 WEST STREET, 19TH FLOOR

NEW YORK NY 10036**

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

**NORTHERN TRUST
50 SOUTH LASALLE STREET

CHICAGO IL 60603**

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

WINSLOW CAPITAL MANAGEMENT LLC
4400 IDS CENTER
80 SOUTH EIGHTH STREET
MINNEAPOLIS MN 55402

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

VINTAGE VI MGT LP
200 WEST STREET
NEW YORK NY 10282-2198

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

ENTRUST CAPITAL DIVERSIFIED ** - *** 5262

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

RREEF AMERICA REIT II ** - *** 4506

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

RCP MULTI-STRATEGY FUND
353 NORTH CLARK STREET, STE 3500
CHICAGO IL 60654

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

CHURCHILL
333 W WACKER DR
CHICAGO IL 60606

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

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

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

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

MARQUETTE ASSOCIATES, INC.
18900 N. LASALLE STE 3500
Chicago IL 60601

(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?
50 27	NONE	70000	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)

TIC MIDWEST
11590 NORTH MERIDIAN ST
CARMEL IN 46032

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 38 15 13 10	NONE	61638	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)

WATKINS PAWLICK CALATI & PRIFTI PC ****-***3229**

(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?
50 29	NONE	29372	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

COMERICA BANK

** - ***7375

(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 19 NONE		28161	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

UNITED ACTUARIAL SERVICES

** - ***6428

(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?
50 11 NONE		25250	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)

BENDA, GRACE, STULZ & COMPANY, P.C. ** - ***4921

(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?
50 10 NONE		24050	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

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

Part II | Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). u File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning _____ and ending _____

A Name of plan	B Three-digit plan number (PN) u	001
OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND		

C Plan or DFE sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
TRUSTEES OF OUTSTATE MICHIGAN	** - *** 2545

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: **SHORT TERM INVESTMENT FUND**

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

c EIN-PN ** - *** 7511 001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1279814
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a Name of MTIA, CCT, PSA, or 103-12 IE: **NT COLLECTIVE ALL COUNTRY WORLD ex-US MARKET**

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

c EIN-PN ** - *** 8589 128	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	12120247
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a Name of MTIA, CCT, PSA, or 103-12 IE: **NT COLLECTIVE RUSSELL 3000 INDEX FUND**

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

c EIN-PN ** - *** 8589 005	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	27049854
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a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

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

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

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

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

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

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

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

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

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

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

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

**SCHEDULE H
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Financial Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning

and ending

A Name of plan	B Three-digit plan number (PN) ▶	001
OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
TRUSTEES OF OUTSTATE MICHIGAN	** - ***2545	

Part I Asset and Liability Statement

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

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	972,235	922,215
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	262,633	210,036
(2) Participant contributions		
(3) Other	2,889,372	69,195
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)		
(2) U.S. Government securities		
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred		
(B) All other		
(4) Corporate stocks (other than employer securities):		
(A) Preferred		
(B) Common	0	
(5) Partnership/joint venture interests	15,968,239	16,420,846
(6) Real estate (other than employer real property)	6,877,170	6,578,905
(7) Loans (other than to participants)		
(8) Participant loans		
(9) Value of interest in common/collective trusts	38,582,624	40,449,915
(10) Value of interest in pooled separate accounts		
(11) Value of interest in master trust investment accounts		
(12) Value of interest in 103-12 investment entities		
(13) Value of interest in registered investment companies (e.g., mutual funds)	14,609,800	20,577,219
(14) Value of funds held in insurance company general account (unallocated contracts)		
(15) Other See Statement 1	1,358,103	1,088,871

	(a) Beginning of Year	(b) End of Year
1d Employer-related investments:		
(1) Employer securities	1d(1)	
(2) Employer real property	1d(2)	
e Buildings and other property used in plan operation	1e	21,065
f Total assets (add all amounts in lines 1a through 1e)	1f	81,541,241
Liabilities		
g Benefit claims payable	1g	
h Operating payables	1h	196,704
i Acquisition indebtedness	1i	
j Other liabilities	1j	151,072
k Total liabilities (add all amounts in lines 1g through 1j)	1k	347,776
Net Assets		
l Net assets (subtract line 1k from line 1f)	1l	81,193,465
		86,164,714

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	(a) Amount	(b) Total
Income		
a Contributions:		
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	4,068,218
(B) Participants	2a(1)(B)	
(C) Others (including rollovers)	2a(1)(C)	
(2) Noncash contributions	2a(2)	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	4,068,218
b Earnings on investments:		
(1) Interest:		
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	10,395
(B) U.S. Government securities	2b(1)(B)	
(C) Corporate debt instruments	2b(1)(C)	
(D) Loans (other than to participants)	2b(1)(D)	
(E) Participant loans	2b(1)(E)	
(F) Other	2b(1)(F)	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	10,395
(2) Dividends: (A) Preferred stock	2b(2)(A)	
(B) Common stock	2b(2)(B)	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	1,353,297
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	1,353,297
(3) Rents	2b(3)	
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	8,185,480
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	8,185,480
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	-354,504
(B) Other	2b(5)(B)	-18,608
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	-373,112

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	6,817,543
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	-332,581
c Other income	2c	9,043
d Total income. Add all income amounts in column (b) and enter total	2d	11,552,803

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	6,142,541
(2) To insurance carriers for the provision of benefits	2e(2)	
(3) Other	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	6,142,541
f Corrective distributions (see instructions)	2f	
g Certain deemed distributions of participant loans (see instructions)	2g	
h Interest expense	2h	
i Administrative expenses:		
(1) Salaries and allowances	2i(1)	
(2) Contract administrator fees	2i(2)	69,502
(3) Recordkeeping fees	2i(3)	17,336
(4) IQPA audit fees	2i(4)	22,600
(5) Investment advisory and management fees	2i(5)	142,795
(6) Bank or trust company trustee/custodial fees	2i(6)	28,161
(7) Actuarial fees	2i(7)	23,900
(8) Legal fees	2i(8)	29,372
(9) Valuation/appraisal fees	2i(9)	
(10) Other trustee fees and expenses	2i(10)	6,508
(11) Other expenses	2i(11)	98,839
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)	439,013
j Total expenses. Add all expense amounts in column (b) and enter total	2j	6,581,554

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	4,971,249
l Transfers of assets:		
(1) To this plan	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **BENDA, GRACE, STULZ & COMPANY, P.C.** (2) EIN: **** - ***4921**

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

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

Part IV Compliance Questions

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

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)

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.)

c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)

d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)

e Was this plan covered by a fidelity bond?

f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?

g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?

h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?

i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)

j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)

k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?

l Has the plan failed to provide any benefit when due under the plan?

m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)

n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.

	Yes	No	Amount
4a		X	
4b		X	
4c		X	
4d		X	
4e	X		500000
4f		X	
4g	X		16420846
4h		X	
4i	X		
4j	X		
4k		X	
4l		X	
4m		X	
4n			

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

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

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

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

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

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 561337.

**SCHEDULE R
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

u File as an attachment to Form 5500.

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning and ending

A Name of plan

OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND

B Three-digit plan number (PN) **u**

001

C Plan sponsor's name as shown on line 2a of Form 5500

TRUSTEES OF OUTSTATE MICHIGAN

D Employer Identification Number (EIN)

**** - *** 2545**

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

1

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

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

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month ___ Day ___ Year ___

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)

6a

b Enter the amount contributed by the employer to the plan for this plan year

6b

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)

6c

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer **MAJOR CEMENT CO**
b EIN **** - ***4512** **c** Dollar amount contributed by employer **558779**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **FESSLER & BOWMAN**
b EIN **** - ***9144** **c** Dollar amount contributed by employer **488185**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **EARLEY AND ASSOCIATES, INC.**
b EIN **** - ***0813** **c** Dollar amount contributed by employer **291293**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **ANGELO IAFRATE CONSTRUCTION**
b EIN **** - ***4432** **c** Dollar amount contributed by employer **198835**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **GRANGER CONSTRUCTION CO**
b EIN **** - ***0255** **c** Dollar amount contributed by employer **169219**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer **AJAX PAVING INDUSTRIES, INC**
b EIN **** - ***3205** **c** Dollar amount contributed by employer **167809**
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**
e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)
 (1) Contribution rate (in dollars and cents) _____
 (2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer **BNA CONTRACTORS usa jv**

b EIN **** - ***4855** **c** Dollar amount contributed by employer **148679**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**

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

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

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

a Name of contributing employer **GM & SONS, INC.**

b EIN **** - ***3614** **c** Dollar amount contributed by employer **134511**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**

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

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

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

a Name of contributing employer **DOAN CONSTR CO**

b EIN **** - ***9563** **c** Dollar amount contributed by employer **133165**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**

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

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

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

a Name of contributing employer **C.A. HULL, INC.**

b EIN **** - ***8683** **c** Dollar amount contributed by employer **109091**

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **06** Day **01** Year **2025**

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

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

14a	16
14b	16
14c	16

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

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

15a	1.00
15b	1.00

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

- a Enter the number of employers who withdrew during the preceding plan year
- 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

16a	
16b	

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

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

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

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

- a Enter the percentage of plan assets held as:
Public Equity: 46.4 % Private Equity: 19.1 % Investment-Grade Debt and Interest Rate Hedging Assets: 23.9 %
High-Yield Debt: _____ % Real Assets: 7.6 % Cash or Cash Equivalents: 1.7 % Other: 1.3 %
- b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

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

- a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero Yes No
- b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation. _____

Part VII IRS Compliance Questions

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

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

- Design-based safe harbor method
- "Prior year" ADP test
- "Current year" ADP test
- N/A

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

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Federal StatementsFYE: 12/31/2020 **OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND****Plan: 001****Statement 1 - Form 5500, Schedule H, Line 1c(15) - Other Investments**

Description	BOY Amount	EOY Amount
Hedge Fund of Funds	\$ 1,358,103	\$ 1,088,871
Total	\$ 1,358,103	\$ 1,088,871

Statement 2 - Form 5500, Schedule H, Line 1j - Other Liabilities

Description	BOY Amount	EOY Amount
UNSETTLED INVESTMENT TRANS	\$ 151,072	\$
Total	\$ 151,072	\$ 0

Statement 3 - Form 5500, Schedule H, Line 2c - Other Income

Description	Amount
LIQUIDATED DAMAGES	\$ 3,762
LITIGATION SETTLEMENTS	5,281
Total	\$ 9,043

Statement 4 - Form 5500, Schedule H, Line 2i(4) - Other Expenses

Description	Amount
PBGC PREMIUM	\$ 49,950
PRINTING & MISCELLANEOUS	16,869
TRUSTEE & FIDUCIARY INSURANCE	16,391
MEMBER COMMUNICATIONS	7,403
EDUCATION & AFFILIATION DUES	5,685
LOCKBOX & BANK SERVICE CHARGES	2,541
Total	\$ 98,839

Statement 5 - Schedule H, Line 4i - Schedule of Assets Held for Investment

Party in Interest	Identity	Description	Cost	Current Value
	SEE ATTACHED FINANCIAL STATEMENTS		\$	\$

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FYE: 12/31/2024

Federal Statements
OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND
Plan: 001

Statement 6 - Schedule H, Line 4j - Schedule of Reportable Transactions (5%)

<u>Name</u>								
<u>Description</u>	<u>Purchase Price</u>	<u>Selling Price</u>	<u>Lease Rental</u>	<u>Expenses</u>	<u>Cost of Asset</u>	<u>Current Value</u>	<u>Net Gain or Loss</u>	
SEE ATTACHED FINANCIAL STMT	\$	\$	\$	\$	\$	\$	\$	\$

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Federal Statements

FYE: 12/31/2020 **OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND**

Plan: 001

Statement 7 - Schedule MB, line 11 - Justification for Change in Actuarial Assumptions

Description

See attached change in Actuarial Assumptions.

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 FYE: 12/31/2024

Federal Statements
OUTSTATE MICHIGAN TROWEL TRADES PENSION FUND
Plan: 001

Statement 8 - Schedule MB, line 9c - Schedule of funding Standard Account Bases

Description	Date	Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount	Amortization Basis
Employer		\$		\$ 32,531,070		\$ 5,673,348	Other

Multi-Employer

Statement 9 - Schedule MB, line 9h - Schedule of Funding Standard Account Bases

Description	Date	Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount
Employer		\$		\$ 6,603,532		\$ 1,750,196
Total		\$	0	\$ 6,603,532		\$ 1,750,196