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 6047(e), 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

2015

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

A This return/report is for: [X] a multiemployer plan; [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the forms instr.); or

[ ] a single-employer plan; [ ] a DFE (specify) _____

B This return/report is: [ ] the first return/report; [ ] the final return/report;

[ ] an amended return/report; [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶ [X]

D Check box if filing under: [X] Form 5558; [ ] automatic extension; [ ] the DFVC program;

[ ] special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 04/11/1958

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)
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

1 WALL STREET

BURLINGTON MA 01803-4768

2b Employer Identification Number (EIN) 04-6372430

2c Plan Sponsor's telephone number 781-345-4400

2d Business code (see instructions) 484120

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	[signature]	7/10/2017	SEAN OBRIEN (UNION TRUSTEE)
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	[signature]	6/22/17	FRANK KELLER (EMPLOYER TRUSTEE)
	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

Preparer's name (including firm name, if applicable) and address (include room or suite number)

Preparer's telephone number

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	71865
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a (1)	Total number of active participants at the beginning of the plan year	**6a(1)**	19701
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	20392
b	Retired or separated participants receiving benefits	**6b**	24193
c	Other retired or separated participants entitled to future benefits	**6c**	19799
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	64384
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	7614
f	Total. Add lines **6d** and **6e**	**6f**	71998
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	395

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

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

9a Plan funding arrangement (check all that apply)

- (1) [ ] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) [ ] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

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

a Pension Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2015** **This Form is Open to Public Inspection.**

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)
04-6372430

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

ST CLOUD CAPITAL PARTNERS 20-4615136
10866 WILSHIRE BLVD
LOS ANGELES CA 90210

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

NEWSTONE CAPITAL 77-0661362
1111 SANTA MONICA BLVD
LOS ANGLES CA 90024

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

ENTRUST 13-4075262
375 PARK AVENUE
NEW YORK NY 10152

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

TREMONT REALTY 20-5240386
THE PRUDENTIAL TOWER
BOSTON MA 02199

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

PRECO II - PRUDENTIAL INSURANCE 86-1064052
8 CAMPUS DRIVE
PARSIPPANY NJ 07054

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

PRECO III - PRUDENTIAL INSURANCE 20-4053134
8 CAMPUS DRIVE
PARSIPPANY NJ 07054

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

PRECO IV - PRUDENTIAL INSURANCE 26-2806036
8 CAMPUS DRIVE
PARSIPPANY NJ 07054

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

INTERCONT. REAL EST. INV. FUND III 04-3549299
1270 SOLDER FIELD ROAD
BOSTON MA 02135

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

BBH CAPITAL PARTNER IV 27-5494700
140 BROADWAY
NEW YORK NY 10005

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

ABS ALPHA GLOBAL EQUITIES 98-0544028
55 RAILROAD AVE
GREENWICH CT 06830

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

ALINDA INFRASTRUCTURE FUND I 03-0601879
150 EAST 58TH STREET
NEW YORK NY 10155

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

INTERCONTINENTAL US REAL ESTATE FUN 11-3786306
1270 SOLDER FIELD ROAD
BOSTON MA 02135

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	2015 This Form is Open to Public Inspection.

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NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

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04-6372430

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

LEVINE LEICHTMAN PTR IV 03-0395290
335 NORTH MAPLE DRIVE
BEVERLY HILLS CA 90210

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

LEVINE LEICHTMAN DEEP VALUE 86-1129583
335 NORTH MAPLE DRIVE
BEVERLY HILLS CA 90210

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

ALINDA INFRASTRUCTURE FUND II 26-2932089
100 WEST PUTNAM AVENUE, 3RD FLOOR
GREENWICH CT 06830

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

ABS INVESTMENT MANAGEMENT, LLC 13-4205457
537 STEAMBOAT RD
GREENWICH CT 06830

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

AQR GLOBAL RISK PREMIUM 98-1032119
TWO GREENWICH PLAZA, 3RD FLOOR
GREENWICH CT 06830

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

BBH CAPITAL PARTNERS III 01-0888878
140 BROADWAY
NEW YORK NY 10005

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

CRESCENT MEZZANINE PARTNERS 80-0790681
11100 SANTA MONICA BLVD, SUITE 2000
LOS ANGELES CA 90025

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

ENTRUST SPECIAL OPPORTUNITIES FUND 90-0644478
375 PARK AVENUE, 24TH FLOOR
NEW YORK NY 10152

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

LEVINE LEICHTMAN PTR II 26-1936690
335 NORTH MAPLE DRIVE, SUITE 130
BEVERLY HILLS CA 90210

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

CRESCENT HIGH INCOME FUND 45-5287411
11100 SANTA MONICA BLVD, SUITE 2000
LOS ANGELES CA 90025

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

RREEF AMERICAN REIT 36-4215573
222 S. RIVERSIDE PLAZA
CHICAGO IL 60606

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

OAKTREE CAPITAL MANAGEMENT 26-0174894
333 SOUTH GRAND AVE, 28TH FLOOR
LOS ANGELES CA 90007

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	2015 This Form is Open to Public Inspection.

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D Employer Identification Number (EIN)
04-6372430

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

ASB ALLEGIANCE REAL ESTATE FUND 52-6257033
7501 WISCONSIN AVE, SUITE 1500W
BETHESDA MD 20814

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

ALINDA INFRASTRUCTURE FD III 98-1210428
100 WEST PUTNAM AVENUE, 3RD FLOOR
GREENWICH CT 06830

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

AFL-CIO BIT 52-6328901
ONE EAST PRATT STREET 5TH FLOOR EAS
BALTIMORE MD 21202

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

BLACKSTONE REAL ESTATE PARTNER 26-0288589
345 PARK AVENUE
NEW YORK NY 10154

(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 2, 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).

SEE STATEMENT 1

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

MARQUETTE ASSOCIATES 36-3485298
180 N LASALLE
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?
27 50	NONE	1405033.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ROBECO INVESTMENT MANAGEMENT, INC. 98-0202744
909 THIRD AVE
NEW YORK NY 10022

(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	883396.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FEINBERG, CAMPBELL & ZACK 04-2738936
177 MILK STREET
BOSTON MA 02109

(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	665699.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

MONDRIAN 98-0117968
TWO COMMERCE SQUARE
PHILADEPHIA PA 19103

(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	593500.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DRIEHAUS CAPITAL MANAGEMENT 20-3634295
PO BOX 10127
CHICAGO IL 60610

(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	588031.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

AM WINS BROKERAGE 22-3297313
PO BOX 60343
CHARLOTTE NC 28260

(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?
22 50	NONE	507606.	Yes ☒ No ☐	Yes ☒ No ☐	0.	Yes ☒ No ☐

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 2, 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).

SEE STATEMENT 1

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

SIERRA INVESTMENT (TEMPLETON) 68-0370668
PO BOX 5727
VACAVILLE CA 95696

(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 99	NONE	505531.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HORIZON 53-0181291
8601 GEORGIA AVE
SILVER SPRING MD 20910

(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	405598.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MORGAN, LEWIS & BOCKIUS 23-0891050
PO BOX 8500
PHILADELPHIA PA 19178

(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	334200.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

STATE STREET GLOBAL ADVISORS 13-1868136
BOX 5488
BOSTON MA 02284

(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	254484.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GAMCO 13-4044521
ONE CORPORATE CENTER
RYE NY 10580

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	241924.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DARCANGELO & CO.,LLP 13-2550103
120 LOMOND CT
UTICA NY 13502

(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	200445.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

STATE STREET BANK & TRUST 04-1867445
200 NEW PORT AVE
QUINCY MA 02171

(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?
25 28 99	NONE	185833.	Yes [X] No [ ]	Yes [X] No [ ]	0.	Yes [X] No [ ]

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

USI INSURANCE SVCS OF MA, INC. 04-6040652
P.O. BOX 3716
NORFOLK VA 23514

(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?
23 50	NONE	160751.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ROTHSCHILD 46-2780207
1251 AVE OF THE AMERICAS 34TH FLOOR
NEW YORK NY 10020

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	129313.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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 2, 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).

SEE STATEMENT 1

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

HAYS COMPANIES 41-1981007
NCB-88 PO BOX 1414
MINNEAPOLIS MN 55480

(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?
16 50	NONE	116104.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ZIEGLER CAPITAL MGMT, LLC 43-1273600
70 WEST MADISON, SUITE 2400
CHICAGO IL 60602

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	116083.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SB FERNANDES & COMPANY 03-
201 BIRCH KNOLL RD
RUTLAND VT 05701

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	70125.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

THE MATHIS GROUP 26-0289817
923 FIFTEENTH ST
WASHINGTON DC 20005

(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?
16 50	NONE	52000.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WARREN BUSINESS GRAPHICS 04-2471984
1377 MAIN STREET
WALTHAM MA 02451

(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?
38 50	NONE	42857.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STANDISH 25-1890416
DEPT 81029
WOBURN MA 01813

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	40493.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

PKF ACCOUNTANTS & BUSINESS ADVISORS 04-3138777
99 SUMMER ST
BOSTON MA 02110

(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	18750.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INTEGRA, LEGGAT, MCCALL & WERNER 04-2492676
313 CONGRESS STREET SUITE 100
BOSTON MA 02210

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	17000.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GALLAGHER FIDUCIARY ADVISORS 36-4291971
PO BOX 71396
CHICAGO IL 60694

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	15263.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

WB MASON 04-2455641
59 CENTRE ST
BROCKTON MA 02301

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	10635.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LANSA 36-4067691
6762 EAGLE WAY
CHICAGO IL 60678

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	9500.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

THE BERWYN GROUP 34-1672337
PARK CENTER
BEACHWOOD OH 45263

(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?
17 50	NONE	9495.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

MASS MUTUAL LIFE INSURANCE CO. 04-1590850
1295 STATE ST. F205
SPRINGFIELD MA 01111

(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?
23 22 50	NONE	9001.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

COMPU-CALL 51-0288326
252 JOHN DIETSCH BLVD
NORTH ATTLEBORO MA 02763

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	8685.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SUN LIFE FINANCIAL 38-1082080
PO BOX 0760
CAROL STREAM IL 60132

(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 23	NONE	8664.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

NATIONAL COORDINATING 52-1041104
815 16TH STREET
N.W. WASHINGTON DC 20006

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	8250.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PROXYVOTE PLUS 76-0702630
1200 SHERMER RD, SUITE 216
NORTHBROOKE IL 60062

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	7200.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CORPORATE RISK ADVISORS 04-2532724
PO BOX 290788
BOSTON MA 02129

(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?
23 50	NONE	7103.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

VANGUARD SYSTEMS INC 23-2493967
2901 DUTTON MILL RD SUITE 220
ASTON PA 19014

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	6300.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VERIZON WIRELESS 23-2259884
PO BOS 4003
ACWORTH GA 30101

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	6244.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PITNEY BOWES GLOBAL 20-1344287
500 ROSS ST, STE 154-0470
PITTSBURGH PA 15262-0001

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	5999.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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 2, 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).

SEE STATEMENT 1

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

XEROX CORPORATION 16-0468020
PO BOX 827598
PHILADELPHIA PA 19182

(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?
36 50	NONE	5958.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MACKENZIE & COMPANY, LLC 45-3415260
5 S. CHELMSFORD RD
WESTFORD MA 01886

(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	5575.	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

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).

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

OMB No. 1210-0110

2015

This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FU

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)
04-6372430

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: RUSSELL 1000 VALUE FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-0025081 015 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 97793445.

a Name of MTIA, CCT, PSA, or 103-12 IE: MSCI EMERGING MARKETS FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-3407623 001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 21799445.

a Name of MTIA, CCT, PSA, or 103-12 IE: MSCI EAFE (NON LENDING) INDEX FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-0025081 240 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 123501206.

a Name of MTIA, CCT, PSA, or 103-12 IE: S&P FLAGSHIP FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-0025081 002 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 269856764.

a Name of MTIA, CCT, PSA, or 103-12 IE: AGGREGATE BOND INDEX NL FUND

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR

c EIN-PN 04-0025081 070 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 135446727.

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)

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)

(Complete as many entries as needed to report all participating plans)

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

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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)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	2015 This Form is Open to Public Inspection

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

A Name of plan

NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FU

B Three-digit plan number (PN) ▶ 001

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

NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)

04-6372430

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	64259976	79984060
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1639865632	1723183452
(2) Participant contributions	1b(2)		
(3) Other SEE STATEMENT 2	1b(3)	26339864	12829883
c General investments:			
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)	19041914	22455674
(2) U.S. Government securities	1c(2)	88814676	75407989
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	16089878	29159826
(B) All other	1c(3)(B)	10429463	21931354
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		925086
(B) Common	1c(4)(B)	491999629	535230770
(5) Partnership/joint venture interests	1c(5)	1159857393	1183150560
(6) Real estate (other than employer real property)	1c(6)	360381265	80852727
(7) Loans (other than to participants)	1c(7)	2907552	2846053
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	573132293	648397587
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance co. general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1 d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e	6705212	186618
f	Total assets (add all amounts in lines 1a through 1e)	1f	4459824747	4416541639
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	1102214	654916
i	Acquisition indebtedness	1i	100000000	
j	Other liabilities SEE STATEMENT 3	1j	40723375	30009310
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	141825589	30664226
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	4317999158	4385877413

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	449069508	
(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)		449069508
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	90470	
(B) U.S. Government securities	2b(1)(B)	1184278	
(C) Corporate debt instruments	2b(1)(C)	1317581	
(D) Loans (other than to participants)	2b(1)(D)	244783	
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	32503072	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		35340184
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	16776075	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		16776075
(3) Rents	2b(3)		1247072
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	681112573	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	677178507	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		3934066
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)	5680295	
(B) Other	2b(5)(B)	50643215	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		56323510

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		72964892
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income SEE STATEMENT 4	2c		83722
d Total income. Add all **income** amounts in column (b) and enter total	2d		635739029
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	543450498	
(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)		543450498
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	1628789	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)	16910288	
(4) Other SEE STATEMENT 5	2i(4)	5871199	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		24410276
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		567860774
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		67878255
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) [X] 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 [X] No

c Enter the name and EIN of the accountant (or accounting firm) below:
(1) Name: DARCANGELO & CO.,LLP (2) EIN: 13-2550103

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	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X		
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X		

		Yes	No	N/A	Amount
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.)	4c		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
e Was this plan covered by a fidelity bond?	4e	X			20000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g	X			2846053
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?	4h		X		
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X		
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		X		
o Did the plan trust incur unrelated business taxable income?	4o				
p Were in-service distributions made during the plan year?	4p				

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

Part V Trust Information

6a Name of trust

6b Trust's EIN

6c Name of trustee or custodian

6d Trustee's or custodian's telephone number

SCHEDULE MB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
New England Teamsters & Trucking Industry Pension Plan

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
New England Teamsters & Trucking Industry Pension Fund

D Employer Identification Number (EIN)
04-6372430

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

1a	Enter the valuation date: Month 10 Day 1 Year 2015		
b	Assets		
(1)	Current value of assets	1b(1)	2,877,514,938
(2)	Actuarial value of assets for funding standard account	1b(2)	2,922,234,390
c (1)	Accrued liability for plan using immediate gain methods	1c(1)	7,776,936,388
(2)	Information for plans using spread gain methods:		
(a)	Unfunded liability for methods with bases	1c(2)(a)	
(b)	Accrued liability under entry age normal method	1c(2)(b)	
(c)	Normal cost under entry age normal method	1c(2)(c)	
(3)	Accrued liability under unit credit cost method	1c(3)	7,776,936,388
d	Information on current liabilities of the plan:		
(1)	Amount excluded from current liability attributable to pre-participation service (see instructions)	1d(1)	
(2)	"RPA '94" information:		
(a)	Current liability	1d(2)(a)	15,415,160,158
(b)	Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	367,309,078
(c)	Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	565,389,082
(3)	Expected plan disbursements for the plan year	1d(3)	555,413,184

Statement by Enrolled Actuary

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

SIGN HERE

Signature of actuary

6/5/2017
Date

Stanley I. Goldfarb
Type or print name of actuary

17-03401
Most recent enrollment number

Horizon Actuarial Services, LLC
Firm name

(240)247-4512
Telephone number (including area code)

8601 Georgia Ave NW, Suite 700
Silver Spring MD 20910
Address of the firm

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

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)		**2a**	2877514938
b "RPA '94" current liability/participant count breakdown:	**(1)** Number of participants		**(2)** Current liability
(1) For retired participants and beneficiaries receiving payment	32433		6414294715
(2) For terminated vested participants	20396		2922672364
(3) For active participants:			
(a) Non-vested benefits			288664663
(b) Vested benefits			5789528416
(c) Total active	19701		6078193079
(4) Total	72530		15415160158
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage		**2c**	18.6700 %

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
04/01/2016	367982963				
			Totals ▶ 3(b)	367982963	3(c)

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))		**4a**	37.60 %
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		**4b**	
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?			☐ Yes ☐ No
d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)?			☐ Yes ☐ No
e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date		**4e**	
f If the 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 ☐		**4f**	

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

a ☐ Attained age normal **b** ☐ Entry age normal **c** ☒ Accrued benefit (unit credit) **d** ☐ Aggregate
e ☐ Frozen initial liability **f** ☐ Individual level premium **g** ☐ Individual aggregate **h** ☐ Shortfall
i ☐ Reorganization **j** ☐ Other (specify):

k If box h is checked, enter period of use of shortfall method		**5k**	/ /
l Has a change been made in funding method for this plan year?			☐ Yes ☒ No
m If line l is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?			☐ Yes ☐ No
n If line l is "Yes," and line m is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method		**5n**	

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability **6a** 3.30 %

	Pre-retirement	Post-retirement
b Rates specified in insurance or annuity contracts	☐ Yes ☒ No ☐ N/A	☐ Yes ☒ No ☐ N/A
c Mortality table code for valuation purposes:		

(1) Males	6c(1)	A			A		
(2) Females	6c(2)	A			A		
d Valuation liability interest rate	6d		%			%	
e Expense loading	6e	6.4 %		N/A	%	X	N/A
f Salary scale	6f	%	X	N/A			
g Estimated investment return on actuarial value of assets for year ending on the valuation date	6g	8.4 %					
h Estimated investment return on current value of assets for year ending on the valuation date	6h	3.0 %					

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	37392874	4150108
4	225697426	25049390

8 Miscellaneous information:

a If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM-DD-YYYY) of the ruling letter granting the approval — 8a

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

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

c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code? — [ ] Yes [X] No

d If line c is "Yes," provide the following additional information:

(1) Was an extension granted automatic approval under section 431(d)(1) of the Code? — [ ] Yes [ ] No

(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended — 8d(2)

(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code? — [ ] Yes [ ] No

(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2)) — 8d(4)

(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension — 8d(5)

(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007? — [ ] Yes [ ] No

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

9 Funding standard account statement for this plan year:

Charges to funding standard account:			
a Prior year funding deficiency, if any	9a		1924112830
b Employer's normal cost for plan year as of valuation date	9b		129469408
c Amortization charges as of valuation date:		Outstanding balance	
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	3275356411	588875293
(2) Funding waivers	9c(2)		
(3) Certain bases for which the amortization period has been extended	9c(3)		
d Interest as applicable on lines 9a, 9b, and 9c	9d		224608890
e Total charges. Add lines 9a through 9d	9e		2867066421
Credits to funding standard account:			
f Prior year credit balance, if any	9f		
g Employer contributions. Total from column (b) of line 3	9g		367982963
		Outstanding balance	
h Amortization credits as of valuation date	9h	344767243	138273700
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i		27392540

j	Full funding limitation (FFL) and credits:				
	(1) ERISA FFL (accrued liability FFL)	**9j(1)**	5456346581		
	(2) "RPA '94" override (90% current liability FFL)	**9j(2)**	11572834781		
	(3) FFL credit			**9j(3)**	
k	**(1)** Waived funding deficiency			**9k(1)**	
	(2) Other credits			**9k(2)**	
l	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)			**9l**	533649203
m	Credit balance: If line 9l is greater than line 9e, enter the difference			**9m**	
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference			**9n**	2333417218

9o	Current year's accumulated reconciliation account:		
	(1) Due to waived funding deficiency accumulated prior to the 2015 plan year	**9o(1)**	
	(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
	(a) Reconciliation outstanding balance as of valuation date	**9o(2)(a)**	
	(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))	**9o(2)(b)**	
	(3) Total as of valuation date	**9o(3)**	
10	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)	**10**	2333417218
11	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions		[X] Yes [ ] No

SCHEDULE R (Form 5500)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 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.	2015 This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 10/01/2015 and ending 09/30/2016

A Name of plan
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F

D Employer Identification Number (EIN)
04-6372430

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 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
EIN(s): _____ _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3 0

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 8.

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

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

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

b Enter the amount contributed by the employer to the plan for this plan year 6b

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer UNITED PARCEL SERVICES
b EIN 36-2407381 **c** Dollar amount contributed by employer 111836088.
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 07 Day 31 Year 2018
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) 6.20
(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:		
a	The current year	**14a**	26970
b	The plan year immediately preceding the current plan year	**14b**	27068
c	The second preceding plan year	**14c**	26966
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:		
a	The corresponding number for the plan year immediately preceding the current plan year	**15a**	99.64
b	The corresponding number for the second preceding plan year	**15b**	100.40
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:		
a	Enter the number of employers who withdrew during the preceding plan year	**16a**	15
b	If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	96294080

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: 20.6 % Investment-Grade Debt: 4.9 % High-Yield Debt: .1 % Real Estate: 3.1 % Other: 71.3 %

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?	☐ Yes	☐ No
20b	If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?	☐ Design-based safe harbor method	☐ ADP/ACP test
20c	If the ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "current year testing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.401(m)-2(a)(2)(ii))?	☐ Yes	☐ No
21a	Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b):	☐ Ratio percentage test	☐ Average benefit test
21b	Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?	☐ Yes	☐ No
22a	Has the plan been timely amended for all required tax law changes?	☐ Yes	☐ No ☐ N/A

22b Date the last plan amendment/restatement for the required tax law changes was adopted _____. Enter the applicable code _____
(See instructions for tax law changes and codes).

22c If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plan that is subject to a favorable IRS opinion or advisory letter, enter the date of that favorable letter and the letter's serial number .

22d If the plan is an individually-designed plan and received a favorable determination letter from the IRS, enter the date of the plan's last favorable determination letter .

23	Is the Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2) has been made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin Islands)?	☐ Yes	☐ No

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 1

NAME	SERVICE CODES
STATE STREET GLOBAL ADVISORS	28
STATE STREET GLOBAL ADVISORS	51
STATE STREET GLOBAL ADVISORS	68
STATE STREET GLOBAL ADVISORS	99

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 2

DESCRIPTION	BEGINNING	ENDING
ACCRUED INCOME RECEIVABLE	1314214.	1708774.
RECEIVABLE FOR SECURITY SOLD	19948453.	5441596.
FOREIGN EXCHANGE RECEIVABLE	5077197.	5679513.
TOTAL TO SCHEDULE H, LINE 1B(3)	26339864.	12829883.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
PAYABLE FOR SECURITY PURCHASED	35646058.	24327852.
FOREIGN EXCHANGE PAYABLE	5077317.	5681458.
TOTAL TO SCHEDULE H, LINE 1J	40723375.	30009310.

SCHEDULE H OTHER INCOME STATEMENT 4

DESCRIPTION	AMOUNT
OTHER INCOME	83722.
TOTAL TO SCHEDULE H, LINE 2C	83722.

SCHEDULE H OTHER ADMINISTRATIVE EXPENSES STATEMENT 5

DESCRIPTION	AMOUNT
ADMINISTRATIVE EXPENSES	5871199.
TOTAL TO SCHEDULE H, LINE 2I(4)	5871199.

Service Provider Affidavit

I certify that I have been specifically authorized in writing by the plan administrator/employer, as applicable, to enter my EFAST2 PIN on this return/report in order to electronically submit this return/report. I further certify that: (1) I will retain a copy of the administrator's/employer's specific written authorization in my records; (2) I have attached to this electronic filing, in addition to any other required schedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 or Form 5500-SF return/report bearing the manual signature of the plan administrator/employer under penalty of perjury; (3) I advised the plan administrator/employer that by selecting this electronic signature option the PDF image of that manual signature will be included with the rest of the return/report posted by the Department of Labor (DOL) on the Internet for public disclosure; and (4) I will communicate to the plan administrator/employer any inquiries and information that I receive from EFAST2, DOL, IRS or PBGC regarding this annual return/report.

	07/10/2017	D'ARCANGELO & CO., LLP
Signature of service provider (optional)	Date	Enter name of individual signing as service provider