

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	4b EIN
a Sponsor's name	4d PN
c Plan Name	

5 Total number of participants at the beginning of the plan year	5	71990
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)	20799
a (2) Total number of active participants at the end of the plan year	6a(2)	20840
b Retired or separated participants receiving benefits	6b	24558
c Other retired or separated participants entitled to future benefits	6c	18989
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	64387
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	7522
f Total. Add lines 6d and 6e	6f	71909
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	809
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	378

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:

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

<p>a Pension Schedules</p> <p>(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input checked="" type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p>	<p>b General Schedules</p> <p>(1) <input checked="" type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information - Small Plan)</p> <p>(3) <input type="checkbox"/> A (Insurance Information)</p> <p>(4) <input checked="" type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p>
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Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

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

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

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

11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110
		2017
		This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018	
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) ** - *** 2430

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

NEWSTONE CAPITAL **** - *** 1362**
1111 SANTA MONICA BLVD
LOS ANGELES **CA 90024**

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

ENTRUST **** - *** 5262**
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 **** - *** 0386**
THE PRUDENTIAL TOWER
BOSTON **MA 02199**

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

PRECO III - PRUDENTIAL INSURANCE **** - *** 3134**
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 ** - *** 6036
8 CAMPUS DRIVE
PARSIPPANY NJ 07054

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

BBH CAPITAL PARTNER IV ** - *** 4700
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 ** - *** 4028
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 ** - *** 1879
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 ** - *** 6306
1270 SOLDER FIELD ROAD
BOSTON MA 02135

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

LEVINE LEICHTMAN PTR IV ** - *** 5290
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 ** - *** 9583
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 ** - *** 2089
100 WEST PUTNAM AVENUE, 3RD FLOOR
GREENWICH CT 06830

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018	
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) ** - *** 2430

Part I Service Provider Information (see instructions)

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- 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

ABS INVESTMENT MANAGEMENT, LLC **** - *** 5457**
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 **** - *** 2119**
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 V **** - *** 4837**
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 **** - *** 0681**
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 ** - ***4478
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 ** - ***6690
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 ** - ***7411
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 II ** - ***5573
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 ** - ***4894
333 SOUTH GRAND AVE, 28TH FLOOR
LOS ANGELES CA 90007

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

ASB ALLEGIANCE REAL ESTATE FUND ** - ***7033
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 ** - ***0428
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 ** - ***8901
ONE EAST PRATT STREET 5TH FLOOR EAS
BALTIMORE MD 21202

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection.
For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018		
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) ** - *** 2430	

Part I Service Provider Information (see instructions)

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- 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

BLACKSTONE REAL ESTATE PARTNER **** - *** 8589**
345 PARK AVENUE
NEW YORK NY 10154

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

BBH CAPITAL PARTNER III **** - *** 8878**
140 BROADWAY
NEW YORK NY 10005

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

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
MARQUETTE ASSOCIATES **-***5298 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	1562500.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
DRIEHAUS CAPITAL MANAGEMENT **-***4295 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	703906.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
MONDRIAN **-***7968 TWO COMMERCE SQUARE PHILADELPHIA 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	686983.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
FEINBERG, CAMPBELL & ZACK 177 MILK STREET BOSTON MA 02109	**-***8936

(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	667166.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
BOSTON PARTNERS 60 EAST 42ND STREET, SUITE 1550 NEW YORK NY 10065	**-***2744

(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	480016.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
SIERRA INVESTMENT (TEMPLETON) PO BOX 5727 VACAVILLE CA 95696	**-***0668

(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	460102.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
UNION INSURANCE GROUP **-***6088 303 W ERIE ST STE310 CHICAGO IL 60654	

(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	460020.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	** - ***4521
GAMCO 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?
28 50	NONE	334223.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	** - ***1050
MORGAN, LEWIS & BOCKIUS 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	318740.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
ROTHSCHILD 1251 AVE OF THE AMERICAS 34TH FLOOR NEW YORK NY 10020 ** - *** 0207	

(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 50	NONE	272333.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
STATE STREET GLOBAL ADVISORS BOX 5488 BOSTON MA 02284 ** - *** 8136	

(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	262082.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
STATE STREET BANK & TRUST 200 NEW PORT AVE QUINCY MA 02171 ** - *** 7445	

(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	243750.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
DARCANGELO & CO., LLP 120 LOMOND CT UTICA NY 13502 ** - *** 0103	

(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	177575.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
ELLIOT GREENLEAF PO BOX 3010 BLUE BELL PA 19422 ** - *** 7189	

(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	172202.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
ZIEGLER CAPITAL MGMT, LLC 70 WEST MADISON, SUITE 2400 CHICAGO IL 60602 ** - *** 3600	

(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 50	NONE	156543.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
CBIZ **-***2098 1845 WALNUT STREET, 14TH FLOOR PHILADELPHIA 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?
11 50	NONE	153700.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***5474
SB FERNANDES & COMPANY 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	84065.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***9745
AMERICAN ARBITRATION ASSOC 13727 NOEL RD STE 700 DALLAS TX 75240	

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	32000.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
HAYS COMPANIES NCB-88 PO BOX 1414 MINNEAPOLIS MN 55480 **-***1007	

(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	29082.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
VINTAGE 16 MASON AVE, UNIT 4 NORTH ATTLEBORO MA 02760 **-***1065	

(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	20673.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
BRIAN RAINVILLE 208 WEST SAINT PAUL AVE CHICAGO IL 60614 **-***8348	

(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	17500.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
INTEGRA REALTY RESOURCES **-***2676 FANEUIL HALL MARKET PLACE 4, SOUTH 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?
34 50	NONE	17000.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***0416
STANDISH 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?
28 51	NONE	15327.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***9333
H5 PO BOX 347549 PITTSBURGH PA 15251	

(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	12427.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
THE MATHIS GROUP 923 FIFTEENTH ST WASHINGTON DC 20005 <div style="text-align: right;">** - ***9817</div>	

(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	11333.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
PJ GREEN, INC. 100 WHITESBORO ST UTICA NY 13504 <div style="text-align: right;">** - ***8577</div>	

(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	10812.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
WB MASON 59 CENTRE ST BROCKTON MA 02301 <div style="text-align: right;">** - ***5641</div>	

(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	10710.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions) SEE STATEMENT 1						
BROADVIEW NETWORKS PO BOX 70268 PHILADELPHIA PA 19176-0268 ** - ***1082						
(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	10085.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
LANSA 6762 EAGLE WAY CHICAGO IL 60678 ** - ***7691						
(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 <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
CONNECTIVITY SYSTEMS, INC. 1220 VALLEY FORGE RD STE 18 PHOENIXVILLE PA 19460 ** - ***1794						
(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	9109.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
MASS MUTUAL LIFE INSURANCE CO.	** - ***0850
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 <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	** - ***2337
THE BERWYN GROUP	
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	8850.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	** - ***1104
NATIONAL COORDINATING	
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 <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions) SEE STATEMENT 1						
FRANK KELLER 1 WALL STREET BURLINGTON MA 01803 <div style="text-align: right;">**-***2430</div>						
(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?
20 50	EMPLOYEE OF	EMPLOYER 7923.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
CORPORATE RISK ADVISORS PO BOX 290788 BOSTON MA 02129 <div style="text-align: right;">**-***2724</div>						
(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	7584.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Enter name and EIN or address (see instructions)						
AM WINS BROKERAGE PO BOX 60343 CHARLOTTE NC 28260 <div style="text-align: right;">**-***7313</div>						
(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	7072.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
LIBERTY MUTUAL PO BOX 2839 NEW YORK NY 10116 ** - *** 3470	

(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	6857.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
PITNEY BOWES GLOBAL 500 ROSS ST, STE 154-0470 PITTSBURGH PA 15262-0001 ** - *** 4287	

(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	6804.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
XEROX CORPORATION PO BOX 827598 PHILADELPHIA PA 19182 ** - *** 8020	

(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	6342.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
VANGUARD SYSTEMS INC **-***3967 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 <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***2630
PROXYVOTE PLUS 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	6000.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	**-***8577
QUALITY BINDER SERVICES 501 AMHERST ST BUFFALO NY 14207	

(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	5610.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(a) Enter name and EIN or address (see instructions)	SEE STATEMENT 1
BIZTECH SOLUTIONS, INC. **-***7150 200 CENTENNIAL AVE, SUITE 200 PISCATAWAY NJ 08854	

(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	5389.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	
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(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)	
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(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2		
(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		
(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 2017 This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning **10/01/2017** and ending **09/30/2018**

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) ** - ***2430

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 ** - ***7987 123	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 46191770.

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

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR		
c EIN-PN ** - ***9812 001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 72206778.

a Name of MTIA, CCT, PSA, or 103-12 IE: **MSCI ACWI EX USA NL FUND**

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR		
c EIN-PN ** - ***7987 159	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 178000625.

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 ** - ***5081 004	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 455764192.

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 ** - ***5081 070	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 115404406.

a Name of MTIA, CCT, PSA, or 103-12 IE: **MID-CAP GROWTH INDEX**

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISOR		
c EIN-PN ** - ***5081 006	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 151525972.

a Name of MTIA, CCT, PSA, or 103-12 IE: **ARISTOTLE SMALL-CAP EQUITY FUND**

b Name of sponsor of entity listed in (a): ARISTOTLE CAPITAL BOSTON, LLC		
c EIN-PN ** - ***5797 003	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 43965350.

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Schedule D (Form 5500) 2017
v. 170203

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
a	Plan name	
b	Name of plan sponsor	c EIN-PN
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b	Name of plan sponsor	c EIN-PN
a	Plan name	
b	Name of plan sponsor	c EIN-PN

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018		

A Name of plan	B Three-digit plan number (PN) ▶	001
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND		
-*2430		

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	67882694	56739275
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1660088216	1677678014
(2) Participant contributions	1b(2)		
(3) Other SEE STATEMENT 2	1b(3)	12915180	8456580
c General investments:			
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)	37828777	26651116
(2) U.S. Government securities	1c(2)	68920201	64623744
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	38242441	30189483
(B) All other	1c(3)(B)	25547803	29539995
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	2525316	495232
(B) Common	1c(4)(B)	442089691	278375118
(5) Partnership/joint venture interests	1c(5)	1068279424	1007128315
(6) Real estate (other than employer real property)	1c(6)	116295262	147908055
(7) Loans (other than to participants)	1c(7)	2779118	2706266
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	894579278	1063059091
(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	191307
f	Total assets (add all amounts in lines 1a through 1e)	1f	4438164708
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	939246
i	Acquisition indebtedness	1i	48088227
j	Other liabilities	1j	32230096
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	81257569
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	4356907139

Part II Income and Expense Statement

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

		(a) Amount	(b) Total
Income			
a	Contributions:		
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	383632240
	(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)	383632240
b	Earnings on investments:		
	(1) Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	274552
	(B) U.S. Government securities	2b(1)(B)	1430863
	(C) Corporate debt instruments	2b(1)(C)	1872865
	(D) Loans (other than to participants)	2b(1)(D)	233430
	(E) Participant loans	2b(1)(E)	
	(F) Other	2b(1)(F)	-5004901
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	-1193191
	(2) Dividends: (A) Preferred stock	2b(2)(A)	5660
	(B) Common stock	2b(2)(B)	8143047
	(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)	8148707
	(3) Rents	2b(3)	
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	795968368
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	746876172
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	49092196
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	18008051
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	18008051

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	90435145
(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	102624
d Total income. Add all income amounts in column (b) and enter total	2d	548225772

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	588979150
(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)	588979150
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)	1607811
(2) Contract administrator fees	2i(2)	
(3) Investment advisory and management fees	2i(3)	14690504
(4) Other SEE STATEMENT 5	2i(4)	5983528
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	22281843
j Total expenses. Add all expense amounts in column (b) and enter total	2j	611260993

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	-63035221
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) Unqualified (2) Qualified (3) Disclaimer (4) Adverse

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

c Enter the name and EIN of the accountant (or accounting firm) below:
 (1) Name: **DARCANGELO & CO., LLP** (2) EIN: **** - *** 0103**

d The opinion of an independent qualified public accountant is **not attached** because:
 (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	

SCHEDULE MB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018

► **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	B Three-digit plan number (PN) ►	001
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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
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E Type of plan: (1) Multiemployer Defined Benefit (2) Money Purchase (see instructions)

1a Enter the valuation date: Month 10 Day 01 Year 2017

b Assets		
(1) Current value of assets	1b(1)	2,706,524,777
(2) Actuarial value of assets for funding standard account	1b(2)	2,793,595,489
c (1) Accrued liability for plan using immediate gain methods	1c(1)	8,206,447,352
(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)	8,206,447,352
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)	16,933,407,604
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	407,487,583
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	596,087,831
(3) Expected plan disbursements for the plan year	1d(3)	596,087,831

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	BRYAN M. MCCORMICK <i>BMM</i> Signature of actuary	<u>06/14/2019</u> Date
	BRYAN M. MCCORMICK Type or print name of actuary	1707345 Most recent enrollment number
	CBIZ Retirement Plan Services Firm name	215-587-0700 Telephone number (including area code)
	1845 WALNUT STREET SUITE 1400 PHILADELPHIA PA 19103-4755 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

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		Yes	No	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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
e Was this plan covered by a fidelity bond?	4e	<input checked="" type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2706266
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
l Has the plan failed to provide any benefit when due under the plan?	4l	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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

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

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

5 c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4138948. (See instr.)

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	2a	2706524777
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	32027	6971917551
(2) For terminated vested participants	19316	3176306853
(3) For active participants:		
(a) Non-vested benefits		289886864
(b) Vested benefits		6495296336
(c) Total active	20799	6785183200
(4) Total	72142	16933407604
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	15.9800 %

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
04-01-2018	356512421				
10-01-2018	9286018				
Totals ▶ 3(b)				365798439	3(c)

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	4a	34.00 %
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	D
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	4e	
f If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here <input checked="" type="checkbox"/>	4f	2033

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

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

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

6 Checklist of certain actuarial assumptions:

a	Interest rate for "RPA '94" current liability	6a	3.01 %												
b	Rates specified in insurance or annuity contracts	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">Pre-retirement</th> <th colspan="3">Post-retirement</th> </tr> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input checked="" type="checkbox"/> No</td> <td style="text-align: center;">N/A</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input checked="" type="checkbox"/> No</td> <td style="text-align: center;">N/A</td> </tr> </table>		Pre-retirement			Post-retirement			Yes	<input checked="" type="checkbox"/> No	N/A	Yes	<input checked="" type="checkbox"/> No	N/A
Pre-retirement			Post-retirement												
Yes	<input checked="" type="checkbox"/> No	N/A	Yes	<input checked="" type="checkbox"/> 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	8.50 %												
e	Expense loading	6e	5.8 %												
f	Salary scale	6f	<input checked="" type="checkbox"/> N/A												
g	Estimated investment return on actuarial value of assets for year ending on the valuation date	6g	7.5 %												
h	Estimated investment return on current value of assets for year ending on the valuation date	6h	8.5 %												

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	19097732	2119592
5	217190196	30508257

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	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
b (2) Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	2732467217
b	Employer's normal cost for plan year as of valuation date	9b	140230535
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)	2786403384	518430965
(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	288245942
e	Total charges. Add lines 9a through 9d	9e	3679374659

Credits to funding standard account:

f	Prior year credit balance, if any	9f	
g	Employer contributions. Total from column (b) of line 3	9g	365798439
		Outstanding balance	
h	Amortization credits as of valuation date	9h	106018738
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i	17086966
j	Full funding limitation (FFL) and credits:		
	(1) ERISA FFL (accrued liability FFL)	9j(1)	3154839195
	(2) "RPA '94" override (90% current liability FFL)	9j(2)	13130796669
	(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	408799083
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	3270575576
9o	Current year's accumulated reconciliation account:		
	(1) Due to waived funding deficiency accumulated prior to the 2017 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	3270575576
11	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold; font-size: 1.2em;">2017</div> This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning 10/01/2017 and ending 09/30/2018

A Name of plan NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUN	B Three-digit plan number (PN) ▶ <u>001</u>
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) ** - *** 2430

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	

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

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule R (Form 5500) 2017 v. 170203

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	** - *** 7381	c Dollar amount contributed by employer	160023139.
d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box <input type="checkbox"/> and see instructions regarding required attachment. Otherwise, enter the applicable date.)	Month	Day	Year
	07	31	2023
e Contribution rate information (If more than one rate applies, check this box <input type="checkbox"/> 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:	<input checked="" type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Unit of production <input type="checkbox"/> 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	25932
b	The plan year immediately preceding the current plan year	14b	26901
c	The second preceding plan year	14c	26970
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	96.39
b	The corresponding number for the second preceding plan year	15b	99.74
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	11
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	68540938
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. <input type="checkbox"/>			

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 <input type="checkbox"/>	
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: <u>10.6</u> % Investment-Grade Debt: <u>4.7</u> % High-Yield Debt: <u>.1</u> % Real Estate: <u>5.6</u> % Other: <u>79.0</u> %
b	Provide the average duration of the combined investment-grade and high-yield debt: <input type="checkbox"/> 0-3 years <input checked="" type="checkbox"/> 3-6 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 9-12 years <input type="checkbox"/> 12-15 years <input type="checkbox"/> 15-18 years <input type="checkbox"/> 18-21 years <input type="checkbox"/> 21 years or more
c	What duration measure was used to calculate line 19(b)? <input checked="" type="checkbox"/> Effective duration <input type="checkbox"/> Macaulay duration <input type="checkbox"/> Modified duration <input type="checkbox"/> Other (specify):

SCHEDULE C	OTHER SERVICE PROVIDER SERVICE CODES	STATEMENT	1
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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
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DESCRIPTION	BEGINNING	ENDING
ACCRUED INCOME RECEIVABLE	1649656.	1292695.
RECEIVABLE FOR SECURITY SOLD	3373251.	4606035.
FOREIGN EXCHANGE RECEIVABLE	7892273.	2557850.
TOTAL TO SCHEDULE H, LINE 1B(3)	12915180.	8456580.

SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT	3
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DESCRIPTION	BEGINNING	ENDING
PAYABLE FOR SECURITY PURCHASED	24337232.	18725623.
FOREIGN EXCHANGE PAYABLE	7892864.	2560257.
TOTAL TO SCHEDULE H, LINE 1J	32230096.	21285880.

SCHEDULE H	OTHER INCOME	STATEMENT	4
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DESCRIPTION	AMOUNT
OTHER INCOME	102624.
TOTAL TO SCHEDULE H, LINE 2C	102624.

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT	5
DESCRIPTION			AMOUNT
ADMINISTRATIVE EXPENSES			5983528.
TOTAL TO SCHEDULE H, LINE 2I(4)			5983528.