Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Report Identification Information

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110

2023

This Form is Open to Public Inspection

For cale	ndar plan year 2023 or fisc	cal plan year beginning 01/01/2023		and ending 12/31/2023		
	return/report is for:	a multiemployer plan		loyer plan (Filers checking this be mation in accordance with the fo		iting
		X a single-employer plan	a DFE (specify		,	
R This	return/report is:	the first return/report	the final return	report		
2 111151	otam/report is:	onths)				
C If the	plan is a collectively-barg	ained plan, check here				
D Chec	k box if filing under:	Form 5558	automatic exte	nsion	the DFVC program	
2 01.00	K box ii iiiiig ariaoi.	special extension (enter description				
E If this	is a retroactively adopted	plan permitted by SECURE Act section	⁷ 201, check here)		
Part II	Basic Plan Infor	mation—enter all requested informatio	n			
	ne of plan	EALTH & WELFARE BENEFIT PLAN			1b Three-digit plan number (PN) ▶	505
					1c Effective date of pla 01/01/2020	an
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2b Employer Identification Number (EIN) 43-1214734						
LITHKO	CONTRACTING, LLC				2c Plan Sponsor's telephone number 855-412-0916	
	RESCENTVILLE ROAD CHESTER, OH 45069				2d Business code (see instructions) 238900	
Caution	: A penalty for the late o	r incomplete filing of this return/repor	t will be assessed u	unless reasonable cause is es	stablished.	
Under pe	enalties of perjury and other	er penalties set forth in the instructions, I ell as the electronic version of this return	declare that I have	examined this return/report, inclu	uding accompanying sche	
SIGN	Filed with authorized/valid	d electronic signature.	05/28/2024	JAMARA RODRIGUEZ		
HERE	Signature of plan admi	Enter name of individual signi	ng as plan administrator			
	<u> </u>		Date		5 , 20 202 2000	
SIGN						
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual signing	ng as employer or plan sp	onsor
SIGN						

Date

HERE

Signature of DFE

Enter name of individual signing as DFE

	Form 5	5500 (2023)		Pag	ge 2			
3a	Plan adminis	strator's name and address X Same as Plan Sponsor			_		3b Adn	ministrator's EIN
								ninistrator's telephone nber
4		and/or EIN of the plan sponsor or the plan name has changed si an sponsor's name, EIN, the plan name and the plan number fror					4b EIN	
	Sponsor's na	ame					4d PN	
С	Plan Name							
5	Total numbe	er of participants at the beginning of the plan year					5	2919
6	Number of p 6a(2), 6b, 60	participants as of the end of the plan year unless otherwise stated c , and 6d).	d (welfa	are plan	s con	nplete only lines 6a(1),		
a(1) Total nun	mber of active participants at the beginning of the plan year					6a(1)	2919
a(2) Total nun	mber of active participants at the end of the plan year					6a(2)	4910
b	Retired o	or separated participants receiving benefits					6b	10
C	Other ret	tired or separated participants entitled to future benefits					6c	0
d	Subtotal.	. Add lines 6a(2) , 6b , and 6c					6d	4920
е	Decease	ed participants whose beneficiaries are receiving or are entitled to	receiv	e benef	fits		6e	
f	Total. Ad	dd lines 6d and 6e					6f	
g(of participants with account balances as of the beginning of the petitis item)					6g(1)	
g(2) Number of complete	of participants with account balances as of the end of the plan year this item)	ear (on	y define	ed cor	ntribution plans	6g(2)	
h	Number of less than	of participants who terminated employment during the plan year n 100% vested	with ac	crued b	enefi	ts that were	6h	
7	Enter the tot	tal number of employers obligated to contribute to the plan (only	multier	nployer	plans	s complete this item)	7	
	If the plan pr	rovides pension benefits, enter the applicable pension feature corrovides welfare benefits, enter the applicable welfare feature codes 4D 4E 4F 4H 4L 4Q						
9a		g arrangement (check all that apply)			enefit	arrangement (check all tha	at apply)	
	(1) X (2)	Insurance Code section 412(e)(3) insurance contracts		(1) (2)	Ä	Insurance Code section 412(e)(3)	insurance	e contracts
	(3)	Trust		(3)	H	Trust	mourance	, contracts
	(4) X	General assets of the sponsor		(4)	X	General assets of the sp	oonsor	
10		oplicable boxes in 10a and 10b to indicate which schedules are a	-		where	indicated, enter the numb	oer attach	ed. (See instructions)
а	Pension Sc	hedules	b	Genera	al Scl	nedules		
	(1)	R (Retirement Plan Information)		(1)		H (Financial Information)	
	(2)	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information	- Small F	Plan)
	\ - /	Purchase Plan Actuarial Information) - signed by the plan		(3)	X	A (Insurance Information	n) – Num	ber Attached5
		actuary		(4)	П	C (Service Provider Info	rmation)	

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

(4)

(5)

(6)

(3)

(4)

(5)

 $\textbf{SB} \ \ (\text{Single-Employer Defined Benefit Plan Actuarial}$

DCG (Individual Plan Information) – Number Attached _

MEP (Multiple-Employer Retirement Plan Information)

Information) - signed by the plan actuary

Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 202	For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023						
A Name of plan				B Three-digit			
•	FITS HEALTH	& WELFARE BENEFIT PLAN		plan number (PN) 505			
				μ.ω	Training (1 11)		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identification Number (FIN)	
LITHKO CONTRACTING		5 <u>24</u> 5. 1 5 5555			-1214734	,	
-	,						
		rning Insurance Contract Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
` '		ANOE COMPANY					
THE LINCOLN NATIONAL	L LIFE INSURF	ANCE COMPANY					
	(a) NIAIC	(d) Contract or	(e) Approximate nu	ımber of	Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From	(g) To	
			policy or contract	year	()	(3)	
35-0472300	65676	10256572	1130		01/01/2023	12/31/2023	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid		
(1)		6235		(**)		11532	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
		and address of the agent, broke		,	ions or fees were paid		
MERCER HUMAN RESOL	` '	<u> </u>	PAYSPHERE CIRCLE				
WEROER FROM WITH THE OOK	01102 001100		CAGO, IL 60173				
			and other commission	no noid			
(b) Amount of sales ar				d other commissions paid			
commissions pai		(c) Amount		(d) Purpose	e	(e) Organization code	
	0	6940	FEES/BENTECH			3	
	(a) Name a				: fid		
		and address of the agent, broke		n commiss	ions or rees were paid		
MERCER HEALTH & BEN	IEFITS LLC		S PAYSPHERE CIRCLE CAGO, IL 60674				
OHIOAGO, IL 00074							
(1) ((((((((((((((((((Fees and other commissions paid						
(b) Amount of sales ar commissions pai		(c) Amount			e.	(e) Organization code	
Commissions par	6235	4593	BROKER BONUS	(d) Purpose		3	
	0230	4090	2			3	
For Paperwork Reductio	n Act Notice,	see the Instructions for Form	5500.		Sched	dule A (Form 5500) 2023	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
		Food and other commissions paid	(0)					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid						
		Fees and other commissions paid	(e)					
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization					
commissions paid	(c) / illioant	(4) 1 41,5000	code					
(a) Nar	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
commissions paid			couc					
())								
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid						
		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid						
(4)	no and addition of the agent, pronor	, or said, person, or memoralisms or rose note para						
(b) Amount of calca and base		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					

F	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrie	r may be treated as a unit	for purposes of
	Curr	ent value of plan's interest under this contract in the general account at year e	end		
		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year	6c		
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation guarantee		
		(3) guaranteed investment (4) other			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total de destina		7o(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art III							
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	ing purposes if such con	tracts are exp	erience-rated as a uni	t. Where con	tracts cover inc	
8	Benef	it and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision	c	Life insura	ince
	е 🗍	Temporary disability (accident and sickness)	f X Long-term disabil	ity g	Supplemental unem	ployment h	n Prescription	on drug
	iΪ	Stop loss (large deductible)	j HMO contract	· <u></u>	PPO contract	. ,	I Indemnity	-
	- 님			·	110 contract	,	ao	Contract
	m X	Other (specify) EAP						
0		inner rated contracts.						
		ience-rated contracts:		02/1)				
		emiums: (1) Amount received 2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)				
	,	3) Increase (decrease) in amount due but unpair 3) Increase (decrease) in unearned premium res						
		4) Earned ((1) + (2) - (3))				9a(4)		0
	. `	Benefit charges (1) Claims paid				ou(+)		
		2) Increase (decrease) in claim reserves						
	•	B) Incurred claims (add (1) and (2))				9b(3)		0
	,	4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (c						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.		9c(1)(F)				
		(G) Other retention charges				1		
		(H) Total retention	_	_		9c(1)(H)		0
		2) Dividends or retroactive rate refunds. (These	-			9c(2)		
	d s	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	,	3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2)	.)	9e		
10		experience-rated contracts:	orrior.			100		2.40000
		Total premiums or subscription charges paid to o				10a		346988
		f the carrier, service, or other organization incur etention of the contract or policy, other than rep	, ,			10b		0
		fy nature of costs.		. o, . op o a			I	
IA								
_								
Pa	art IV	Provision of Information					7	
		he insurance company fail to provide any inform		lete Schedule	A?	Yes X	No	
12	If the	e answer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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

2023

T CHOICH BOILE	on Guaranty Co	poration		ies are required to provide the information to ERISA section 103(a)(2). This Form is Open to Public Inspection				
For calendar p	lan year 202	23 or fiscal pl	an year beginning 01/01/2023		and e	nding 12/3	1/2023	
A Name of plus BUILDING Y		FITS HEALT	H & WELFARE BENEFIT PLAN			ee-digit n number (PN)) •	505
	C Plan sponsor's name as shown on line 2a of Form 5500 LITHKO CONTRACTING, LLC D Employer Identification Number 43-1214734						tion Number	(EIN)
Part I	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage In (a) Name of in THE LINCOLN	nsurance car		RANCE COMPANY					
		(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or	contract year
(b) E	IN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
35-0472300		65676	400001000 25563	451	451 01/01/202		3	12/31/2023
		mission inforr amount paid	nation. Enter the total fees and to	tal commissions paid. L	ist in line 3	3 the agents, b	rokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
34048				3057				
3 Persons re	ceivina com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	<u> </u>		and address of the agent, broker			sions or fees v	vere paid	
MERCER HEA	ALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674			·	
(b) Amoun	t of sales an	nd base	Fe	es and other commission	ns paid			
	nissions pai		(c) Amount		(d) Purpos	se		(e) Organization code
		34048	3057	BROKER BONUS				3
		(a) Name	and address of the agent, broker	, or other person to who	m commis	sions or fees v	vere paid	
(b) Amount of sales and base Fees and other commissions paid								
	missions pai		(c) Amount		(d) Purpos	se		(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
		Food and other commissions paid	(0)					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid						
		Fees and other commissions paid	(e)					
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization					
commissions paid	(c) / illioant	(4) 1 41,5000	code					
(a) Nar	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
commissions paid			couc					
())								
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid						
		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid						
(4)	no and address of the agent, stener	, or said, person, or memoralisms or rose note para						
(b) Amount of calca and base		Fees and other commissions paid	(e)					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code					

F	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrie	r may be treated as a unit	for purposes of
	Curr	ent value of plan's interest under this contract in the general account at year e	end		
		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year	6c		
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation guarantee		
		(3) guaranteed investment (4) other			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total de destina		7o(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art	III Welfare Benefit Contract Informat If more than one contract covers the same gu the information may be combined for reportin employees, the entire group of such individual	oup of employees of th g purposes if such conf	tracts are expe	erience-rated as a unit	. Where con	tracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	b Dental	С	Vision	C	X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ity g	Supplemental unemp	oloyment h	Prescription drug
	ιĪ	Stop loss (large deductible)	i ☐ HMO contract	k∏	PPO contract		I Indemnity contract
	m		′ ⊔				· ,
9	Ехре	perience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese				0.74	0
	L	(4) Earned ((1) + (2) - (3))				9a(4)	0
	b	3 ()					
		(2) Increase (decrease) in claim reserves				0h/3\	0
		(3) Incurred claims (add (1) and (2))				9b(3) 9b(4)	•
	С	(4) Claims charged				30(4)	
	Ū	(A) Commissions	•	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid ir	n cash, or	redited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		,	include amount entere	d in line 9c(2) .)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	226989
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report				10b	0
IA		ecify nature of costs.					
P	art l	IV Provision of Information					_
11	Dic	id the insurance company fail to provide any informa	tion necessary to comp	lete Schedule	A?	Yes	No
12	If t	the answer to line 11 is "Yes," specify the informatio	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

		parsaant te	EINIOA Section 105(a)(2).				Inspection
For calendar plan year 202	23 or fiscal plar	year beginning 01/01/2023		and en	ding 12/31/20	23	
A Name of plan BUILDING YOUR BENE	FITS HEALTH	& WELFARE BENEFIT PLAN			e-digit number (PN))	505
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identification	Number (EIN)
LITHKO CONTRACTING	S, LLC			43	-1214734		
Part I Informat	ion Concer	ning Insurance Contra	ct Coverage. Fees. a	nd Con	nmissions Pro	vide infor	mation for each contract
		. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rriar						
THE LINCOLN NATIONAL		NICE COMPANY					
THE LINCOLN NATIONAL	LIFE INSURP	INCE COMPANY					
4 > EIN	(c) NAIC	(d) Contract or	(e) Approximate nur		P	olicy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	n	(g) To
35-0472300	65676	10256573	2664		01/01/2023		12/31/2023
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total amount of commissions paid (b) Total amount of fees paid							
6705						16216	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
	(a) Name a	nd address of the agent, broke	r, or other person to whom	commiss	ions or fees were	paid	
MERCER HUMAN RESOL	JRCE CONSU		PAYSPHERE CIRCLE CAGO, IL 60173				
(b) Amount of sales ar	nd hase	F	ees and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose	Э		(e) Organization code
	0	9786	FEES/BENTECH				3
	(a) Name a	nd address of the agent, broke	er, or other person to whom	commiss	ions or fees were	paid	
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIRCLE							
CHICAGO, IL 60674							
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount	(0	d) Purpose	Э		(e) Organization code
	6705	6430	BROKER BONUS				3

(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		.
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
• •	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	y ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

F	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrie	r may be treated as a unit	for purposes of
	Curr	ent value of plan's interest under this contract in the general account at year e	end		
		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation guarantee		
		(3) guaranteed investment (4) other			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total de destina		7o(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Ρ	art l		· -					
		If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	ng purposes if such conf	tracts are expe	erience-rated as a unit	. Where contr	acts	cover individual
8	Bene	efit and contract type (check all applicable boxes)		<u> </u>	·	·		
	а	_	b Dental	с	Vision	d	χı	ife insurance
	-		<u>.</u> H	_			=	
	e		f Long-term disabili		Supplemental unemp	oloyment h	_	Prescription drug
	1 [Stop loss (large deductible)	j HMO contract	k _	PPO contract	ı	Ir	ndemnity contract
	m	X Other (specify) ► AD&D						
_								
9		erience-rated contracts:		0-(4)				
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid.						
		(3) Increase (decrease) in unearned premium rese				9a(4)		0
	-	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				9b(3)		0
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (or				35(4)		
		(A) Commissions	,	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or 🗌 d	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entere	d in line 9c(2) .)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	arrier			10a		489277
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo	, ,			10b		0
IA	Spe	ecify nature of costs.						
11		Provision of Information d the insurance company fail to provide any information the answer to line 11 is "Yes," specify the information		lete Schedule	A?	Yes X	No	
		,,						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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

2023

Pension benefit Guaranty Corporation				ERISA section 103(a)(2)					
For calendar pla	n year 202	3 or fiscal pl	an year beginning 01/01/2023		and e	nding 12/3	1/2023	_	
A Name of plan BUILDING YOU		FITS HEALT	H & WELFARE BENEFIT PLAN			ee-digit n number (PN) •	505	
	C Plan sponsor's name as shown on line 2a of Form 5500 LITHKO CONTRACTING, LLC				· ·	oyer Identifica 3-1214734	tion Number	(EIN)	
OI	n a separa		erning Insurance Contract A. Individual contracts grouped a						
1 Coverage Info	1 Coverage Information:								
(a) Name of insu						,			
(b) EIN		(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year	
		code	identification number	policy or contract		(f)	From	(g) To	
31-0685339		54402	2530	2956	;	01/01/2023	3	12/31/2023	
2 Insurance fee descending or			nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	rokers, and	other persons in	
			nmissions paid		(b) ⊤	otal amount o	f fees paid		
3536								0	
3 Persons rece	iving comn	nissions and	fees. (Complete as many entries	s as needed to report all	persons).				
			and address of the agent, broke			sions or fees v	were paid		
MERCER HEAL	TH & BENI	EFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674					
(b) Amount o	of cales and	d hase	Fe	ees and other commissio	ns paid				
	ssions paid		(c) Amount		(d) Purpos	se		(e) Organization code	
		3537	0	NA				3	
		(a) Name	and address of the agent, broke	r. or other person to who	m commis	sions or fees v	were paid		
		17	3						
(b) Amount o	of sales and	d hase	Fe	ees and other commissio	ns paid				
	ssions paid		(c) Amount		(d) Purpos	se		(e) Organization code	

(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Face and other commissions paid	(0)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	T		T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	ı		.		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
• •	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	y ,	,			
(b) Amount of color and har-		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	•	•			

F	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrie	r may be treated as a unit	for purposes of
	Curr	ent value of plan's interest under this contract in the general account at year e	end		
		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation guarantee		
		(3) guaranteed investment (4) other			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total deductions		7o(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

		. 10.10 5 01.0 1 11.0							
Р	art II	If more than one contract covers the same of the information may be combined for report	group of employees of the ng purposes if such cont	racts are	exp	erience-rated as a unit	. Where co	ontracts of	cover individual
		employees, the entire group of such individe	iai contracts with each ca	arrier may	be.	treated as a unit for pi	urposes of t	nis repo	π.
8	Bene	fit and contract type (check all applicable boxes)				-			
	а	Health (other than dental or vision)	b X Dental		С	Vision		d 📙 Li	fe insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty	g	Supplemental unem	oloyment	h 🗌 P	rescription drug
	i	Stop loss (large deductible)	j HMO contract		k 🗌	PPO contract		I n	demnity contract
	m	Other (specify)							
		1 , , , ,							
9	Expe	rience-rated contracts:							
	•	remiums: (1) Amount received		9a(1))		990388	1	
	(2) Increase (decrease) in amount due but unpaid		9a(2))		0		
		3) Increase (decrease) in unearned premium res		9a(3)			0		
	(4) Earned ((1) + (2) - (3))					9a(4)		990388
	b	Benefit charges (1) Claims paid		9b(1))		825453		
	(2) Increase (decrease) in claim reserves		9b(2))		0		
	(3) Incurred claims (add (1) and (2))					9b(3)		825453
	(4) Claims charged					9b(4)		825453
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)						
		(A) Commissions		9c(1)(A	4)		3537		
		(B) Administrative service or other fees		9c(1)(E			56073		
		(C) Other specific acquisition costs		9c(1)(0			0		
		(D) Other expenses		9c(1)([0		
		(E) Taxes		9c(1)(E	_		9343	_	
		(F) Charges for risks or other contingencies		9c(1)(F			14015		
		(G) Other retention charges		9c(1)(0	3)		0		
		(H) Total retention	<u>.</u>		<u></u>		9c(1)(H)	1	82968
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or		credited.)	9c(2)		0
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits a	after	retirement	9d(1)		0
		(2) Claim reserves					9d(2)		26049
		(3) Other reserves					9d(3)		0
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9	c(2)	.)	9e		0
10	Nor	experience-rated contracts:							
	а	Total premiums or subscription charges paid to c	arrier				10a		
		If the carrier, service, or other organization incurr					401		
		retention of the contract or policy, other than repo ify nature of costs.	rted in Part I, line 2 abov	e, report	amo	ount	10b		
	Spec	ny nature or costs.							
		A Brandalas (1.6							
Р	art I	/ Provision of Information						_	
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Sche	dule	A?	Yes	X No	
12	lf th	e answer to line 11 is "Yes," specify the informati	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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

2023

r ension benefit Guara	anty corporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)	2). Inspection				
For calendar plan year	ar 2023 or fiscal pl	an year beginning 01/01/2023		and er	nding 12/3	1/2023		
A Name of plan BUILDING YOUR B	BENEFITS HEALT	H & WELFARE BENEFIT PLAN			e-digit number (PN)	<u> </u>	505	
C Plan sponsor's na		ine 2a of Form 5500			oyer Identifica 3-1214734	tion Number	(EIN)	
		erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Informa	tion:							
(a) Name of insurance VISION SERVICE PI								
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end of	(f)	Policy or o	ontract year (g) To	
06-1227840	39616	30093452	policy or contrac	ct year		12/31/2023		
2 Insurance fee and descending order		nation. Enter the total fees and total.	al commissions paid. L	ist in line 3	the agents, b	rokers, and o	other persons in	
	otal amount of cor			(b) To	otal amount o	f fees paid		
		16610				•	0	
3 Persons receiving	commissions and	fees. (Complete as many entries	as needed to report all	persons).				
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	sions or fees v	vere paid		
MERCER HEALTH 8	BENEFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674					
(b) Amount of sal	os and base	Fee	es and other commission	ns paid				
commission		(c) Amount		(d) Purpos	е		(e) Organization code	
	16610	0 N	IA				3	
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	sions or fees w	vere paid		
		-				·		
(b) Amount of sal	es and hase	Fee	es and other commission	ns paid				
commission		(c) Amount		(d) Purpose			(e) Organization code	

(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Face and other commissions paid	(0)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	T		T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	ı		.		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
• •	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	y ,	,			
(b) Amount of color and har-		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	•	•			

F	Part	II Investment and Annuity Contract Information			
	art	Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each carrie	r may be treated as a unit	for purposes of
	Curr	ent value of plan's interest under this contract in the general account at year e	end		
		ent value of plan's interest under this contract in separate accounts at year er	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termina			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation guarantee		
		(3) guaranteed investment (4) other			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total de destina		7o(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art I		-					
		If more than one contract covers the same of the information may be combined for reportional employees, the entire group of such individu	ng purposes if such cont	tracts are expe	erience-rated as a unit	. Where cont	racts	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	cx	Vision	d	П	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	_	Supplemental unem		=	Prescription drug
	ίĖ	Stop loss (large deductible)	j HMO contract		PPO contract			Indemnity contract
	· -		J Tilvio contract	κ	11 O contract	•	Ш	indemnity contract
	m	Other (specify)						
_		<u> </u>						
9		erience-rated contracts:		00/4)				
		Premiums: (1) Amount received		9a(1) 9a(2)				
		(2) Increase (decrease) in amount due but unpaid(3) Increase (decrease) in unearned premium rese						
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	-	Benefit charges (1) Claims paid				- σα(+)		
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (or						
		(A) Commissions	······································	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges						0
		(H) Total retention	_	_		9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These	_	_		9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)		_
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	t include amount entere	a in line 90(2).	.)	9e		
10		Total premiums or subscription charges paid to ca	arrier			10a		166082
						IVa		100002
		If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,		•	10b		0
IA	Spec	city nature of costs.						
_	- u - 1	Dravision of Information						
	art I							
11	Did	the insurance company fail to provide any information	ation necessary to comp	lete Schedule	A?	Yes X	No	
12	If th	he answer to line 11 is "Yes," specify the information	on not provided.					

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

 Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2023

This Form is Open to Public Inspection

					inspection				
Part I	Annual Report	Identification Information							
For cale	ndar plan year 2023 or fis	scal plan year beginning 01/01/2023		and ending 12/31/2023					
A This	return/report is for:	a multiemployer plan	employer info	ployer plan (Filers checking this rmation in accordance with the fo	form instructions.)				
		x a single-employer plan	a DFE (specif	y)					
B This	return/report is:	the first return/report	the final return	•					
		an amended return/report	a short plan y	ear return/report (less than 12 m	months)				
C If the	plan is a collectively-bar	gained plan, check here	······································						
D Chec	k box if filing under:	Form 5558	automatic ext	ension	the DFVC program				
		special extension (enter description	on)						
E If this	is a retroactively adopte	d plan permitted by SECURE Act section	201, check here	.1, 171, 313, 413, 337, 337					
Part II	1	rmation—enter all requested informati							
1a Nan	ne of plan				1b Three-digit plan number (PN) ▶	505			
BUILDI	NG YOUR BENEFITS H	EALTH & WELFARE BENEFIT PLAN			1c Effective date of plan	1			
					01/01/2020				
Mail	n sponsor's name (emplo ing address (include roor or town, state or provinc	2b Employer Identification Number (EIN) 431214734							
	Contracting, LLC				2c Plan Sponsor's telephone number 855-412-0916				
2958 Cr	rescentville Road, West (Chester, OH, 45069, USA			2d Business code (see instructions) 238900				
	. a warmatter for the leter	or incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is e	stablished.				
I be done		her penalties set forth in the instructions, well as the electronic version of this return	I declare that I have	examined this return/report, inc	luding accompanying schedu	ules, lete.			
SIGN	KI		5/24/24	Ben Cutton					
HERE	Signature of plan adn	ninistrator	Date	Enter name of individual sign	ing as plan administrator				
SIGN	orginature or plant aut.								
HERE	HERE Signature of employer/plan sponsor Date Enter name of individual signing as					nsor			
	Signature of employe	ITPICALI SPOLISOI	2310						
SIGN									
HERE	Signature of DFE		Date	Enter name of individual sign	ing as DFE				

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

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	Form 5500 (2023)		Pa	age 2		
3a	Plan administrator's name and address X S	same as Plan Sponsor			3b Administra	ator's EIN
					3c Administra	itor's telephone
4	If the name and/or EIN of the plan sponsor of	r the plan name has changed sin	ce the last re	eturn/report filed for this plan,	4b EIN	
а	enter the plan sponsor's name, EIN, the plan Sponsor's name	name and the plan number from	the last lett	иниероп.	4d PN	
С	Plan Name					
5	Total number of participants at the beginning	of the plan year			5	2919
6	Number of participants as of the end of the p 6a(2), 6b, 6c, and 6d).	lan year unless otherwise stated	(welfare pla	ns complete only lines 6a(1),		
a((1) Total number of active participants at the					2919
a((2) Total number of active participants at the				200-12	4910
b	Retired or separated participants receiving					10
С	Other retired or separated participants en					0
d	Subtotal. Add lines 6a(2), 6b, and 6c					4920
е	Deceased participants whose beneficiarie					
f	Total. Add lines 6d and 6e					
g	(1) Number of participants with account palar complete this item)				6g(1)	
g	complete this item)				6g(2)	
h	Number of participants who terminated er less than 100% vested	nployment during the plan year w	ith accrued	benefits that were	. 6h	
7	Enter the total number of employers obligate	d to contribute to the plan (only m	nultiemploye	r plans complete this item)	. 7	
8a	If the plan provides pension benefits, enter the					tions:
b	If the plan provides welfare benefits, enter the 4A 4B 4D 4E 4F 4H 4L 4Q	e applicable welfare feature code	s from the L	ist of Plan Characteristics Code	es in the instruction	ons:
9a	Plan funding arrangement (check all that app	oly)	9b Plan b	enefit arrangement (check all the	nat apply)	
-	(1) Insurance	• •		Insurance		
	(2) Code section 412(e)(3) insuran	ce contracts	(2)	Code section 412(e)(3.) insurance contr	acts
	(3) Trust		(3)	Trust General assets of the	sponsor	
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to	indicate which schedules are att				Gee instructions)
	Pension Schedules	madate which contains are		ral Schedules		
а	(1) R (Retirement Plan Information	۱)	(1)	H (Financial Information	n)	
			(2)	I (Financial Informatio	n – Small Plan)	
	(2) MB (Multiemployer Defined Be Purchase Plan Actuarial Inform		(3)	A (Insurance Informati	on) – Number Att	ached5
	actuary	duony orginal by the plant	(4)	C (Service Provider Inf	ormation)	
	(3) SB (Single-Employer Defined Information) - signed by the pla		(5)	D (DFE/Participating P	lan Information)	
	(4) DCG (Individual Plan Informati		(6)	G (Financial Transaction	on Schedules)	
	(5) MEP (Multiple-Employer Retire	ement Plan Information)				

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Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)	
2520	e plan provides welfare benefits, was the plan subject to 1,101-2.)	the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR
11b Is the	e plan currently in compliance with the Form M-1 filing re	equirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter	- the Bossint Confirmation Code for the 2023 Form M-1	annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the at was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid
Rece	eipt Confirmation Code	