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

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2021 or fiscal plan year beginning 05/01/2021 and ending 04/30/2022

A This return/report is for: [X] a multiemployer plan [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
[ ] a single-employer plan [ ] a DFE (specify) _____

B This return/report is: [ ] the first return/report [ ] the final return/report
[ ] an amended return/report [ ] a short plan year return/report (less than 12 months)

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

D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program
[ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
MICHIGAN BAC PENSION FUND

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 05/01/1989

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)
MICHIGAN BAC PENSION FUND

6525 CENTURION DRIVE

LANSING MI 48917

2b Employer Identification Number (EIN) **-***5943

2c Plan Sponsor's telephone number 517-321-7502

2d Business code (see instructions) 238100

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

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

SIGN HERE	Paul Dunford	12/5/22	Paul Dunford
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Scott Pantaleo	12/5/22	Scott Pantaleo
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor 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**	2834
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)**	1008
a(2) Total number of active participants at the end of the plan year	**6a(2)**	1120
b Retired or separated participants receiving benefits	**6b**	740
c Other retired or separated participants entitled to future benefits	**6c**	900
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	2760
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	234
f Total. Add lines **6d** and **6e**	**6f**	2994
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**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	102

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

1B

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

- (1) [X] **R** (Retirement Plan Information)
- (2) [X] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). **u File as an attachment to Form 5500.**	**2021** **This Form is Open to Public Inspection.**

For calendar plan year 2021 or fiscal plan year beginning **05/01/2021** and ending **04/30/2022**

A Name of plan	**B** Three-digit plan number (PN) **u**	
MICHIGAN BAC PENSION FUND		**001**
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
MICHIGAN BAC PENSION FUND	**38-2895943**	

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). ..... [X] 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

FRANKLIN TEMPLETON INSTITUTION 59-6865210

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

NORTHERN TRUST COMPANY 45-6138589

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

DIMENSIONAL FUND ADVISORS 22-2370029

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

CARILLON
803 W. MICHIGAN STREET
SUITE A
MILWAUKEE WI 53233

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

DOUBLELINE
333 S. GRAND AVE.
18TH FLOOR
LOS ANGELES CA 90071

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

VANGUARD
P.O. BOX 982903

EL PASO TX 79998-2903

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

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

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

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

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

TIC INTERNATIONAL CORPORATION 13-2600875

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 15 14 13 10	NONE	175470	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LSV ASSET MANAGEMENT 20-0726879

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51 28	NONE	172018	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HARRIS INVESTMENT MANAGEMENT 36-3673844

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51 28	NONE	124542	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

AMERICAN REALTY ADVISORS 95-4871432

(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?
52 28	NONE	112463	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

WEDGE CAPITAL PARTNERS 56-1557450

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51 28	NONE	94238	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MEKETA INVESTMENT GROUP 04-2659023

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 27	NONE	75000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

NORTHERN TRUST COMPANY 38-0056147

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 19	NONE	57829	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

UNITED ACTUARIAL SERVCIES, INC. 35-2156428

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 11	NONE	43105	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LEGGHIO & ISRAEL, P.C. 38-1971448

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 29	NONE	31278	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

MORGAN STANLEY GLOBAL BANKING 38-1971448

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 27	NONE	25000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BENDA, GRACE, STULZ & COMPANY, P.C. 38-2284921

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 10	NONE	21700	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEGAL MARCO ADVISORS
P.O. BOX 4142
NEW YORK NY 10261-4142

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 17	NONE	20000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

WATKINS PAWLICK CALATI & PRIFTI PC 83-2893229

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 29	NONE	12909	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TRADE SOLUTIONS
P.O. BOX 1318
Clarkston MI 48347

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 36	NONE	6541	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

Part I **Service Provider Information (continued)**

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

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

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

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

u File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public Inspection.

For calendar plan year 2021 or fiscal plan year beginning **05/01/2021** and ending **04/30/2022**

A Name of plan
MICHIGAN BAC PENSION FUND

B Three-digit plan number (PN) **u** **001**

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
MICHIGAN BAC PENSION FUND

D Employer Identification Number (EIN)
38-2895943

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: **COLLECTIVE SHORT TERM INVESTMENT FD**

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

c EIN-PN **36-6036794 001** | **d** Entity code **C** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **4556197**

a Name of MTIA, CCT, PSA, or 103-12 IE: **INTERNATIONAL VALUE EQUITY TRUST**

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

c EIN-PN **20-0726879 001** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **21658641**

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

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

c EIN-PN **22-2370029 000** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **14150933**

a Name of MTIA, CCT, PSA, or 103-12 IE: **RUSSELL 1000 GROWTH INDEX FUND**

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

c EIN-PN **45-6138589 099** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **15908339**

a Name of MTIA, CCT, PSA, or 103-12 IE: **SCOUT UNCONSTRAINED BOND FUND**

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

c EIN-PN **45-2778711 001** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **9251669**

a Name of MTIA, CCT, PSA, or 103-12 IE: **TOTAL RETURN BOND FUND**

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

c EIN-PN **27-1927859 001** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **4704242**

a Name of MTIA, CCT, PSA, or 103-12 IE: **TOTAL BOND MARKET INDEX FUND**

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

c EIN-PN **90-6083974 222** | **d** Entity code **E** | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **5415027**

a Name of MTIA, CCT, PSA, or 103-12 IE: SHORT TERM INFLATON PROTECTED FUND
b Name of sponsor of entity listed in (a): VANGUARD
c EIN-PN 90-6083974 119 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3203970

a Name of MTIA, CCT, PSA, or 103-12 IE: LONG TERM TREASURY INDEX FUND
b Name of sponsor of entity listed in (a): VANGUARD
c EIN-PN 90-6083974 083 | **d** Entity code E | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 5367987

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

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

u File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning **05/01/2021** and ending **04/30/2022**

A Name of plan

MICHIGAN BAC PENSION FUND

B Three-digit plan number (PN) ▶ **001**

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

MICHIGAN BAC PENSION FUND

D Employer Identification Number (EIN)

38-2895943

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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	804,395	2,001,233
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	40,493	49,312
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1,714,964	2,224,468
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	4,282,715	5,024,028
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	33,332,847	30,968,762
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)	8,871,324	11,378,320
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	1,493,008	4,556,197
(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)	77,942,823	79,660,808
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other See Statement 1	1c(15)	37,502,881	29,454,750

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e	686	1,226
f	Total assets (add all amounts in lines 1a through 1e)	1f	165,986,136	165,319,104
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	457,922	464,513
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	457,922	464,513
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	165,528,214	164,854,591

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)	10,712,304	
	(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)		10,712,304
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)	485,768	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	3,398,549	
	(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		3,884,317
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	33,935,032	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	29,663,256	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		4,271,776
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	2,619,458	
	(B) Other	2b(5)(B)	-2,735,418	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		-115,960

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		4,741
(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)		-6,961,923
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		7,145
d Total income. Add all **income** amounts in column (b) and enter total	2d		11,802,400
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	11,364,580	
(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)		11,364,580
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)	118,185	
(2) Contract administrator fees	2i(2)	145,523	
(3) Investment advisory and management fees	2i(3)	681,090	
(4) Other	2i(4)	166,645	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		1,111,443
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		12,476,023
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-673,623
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):
(1) [X] Unqualified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.
(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:
(1) Name: **BENDA, GRACE, STULZ & COMPANY, P.C.** **(2)** EIN: **38-2284921**

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.)	4a		X	

			Yes	No	Amount
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g	X		29454750
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

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

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

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

5c Was the plan is a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☒ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year **454066**.

SCHEDULE MB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning **05/01/2021** and ending **04/30/2022**

▶ **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

MICHIGAN BAC PENSION FUND

B Three-digit plan number (PN) ▶ **001**

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

MICHIGAN BAC PENSION FUND

D Employer Identification Number (EIN)

38-2895943

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

1a Enter the valuation date: Month **05** Day **01** Year **2021**

b Assets		
(1) Current value of assets	1b(1)	165,528,214
(2) Actuarial value of assets for funding standard account	1b(2)	165,528,214
c (1) Accrued liability for plan using immediate gain methods	1c(1)	193,779,016
(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)	193,779,016
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)	406,737,437
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	7,867,923
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	11,890,201
(3) Expected plan disbursements for the plan year	1d(3)	12,009,698

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

02/06/2023

Signature of actuary — Date

Angela L. Jeffries, EA MAA — **20-08511**

Type or print name of actuary — Most recent enrollment number

United Actuarial Services, Inc. — **317-580-8652**

Firm name — Telephone number (including area code)

11590 N. Meridian Street, Suite 610

Carmel IN 46032-4529

Address of the firm

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

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)		**2a**	**165,528,214**
b "RPA '94" current liability/participant count breakdown:		**(1)** Number of participants	**(2)** Current liability
(1) For retired participants and beneficiaries receiving payment		**885**	**164,142,692**
(2) For terminated vested participants		**859**	**98,510,709**
(3) For active participants:			
(a) Non-vested benefits			**5,063,384**
(b) Vested benefits			**139,020,652**
(c) Total active		**909**	**144,084,036**
(4) Total		**2653**	**406,737,437**
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	**2c**	**40.70** %	

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
04/30/2022	**10712304**				
			Totals u **3(b)**	**10712304**	**3(c)**

(d) Total withdrawal liability amounts included in line 3(b) total	**3(d)**	**0**

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	**4a**	**85.4** %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	**4b**	**N**

c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? ☐ Yes ☐ No

d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? ☐ Yes ☐ No

e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	**4e**	
f If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here ☐	**4f**	

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

a ☐ Attained age normal **b** ☐ Entry age normal **c** ☒ Accrued benefit (unit credit) **d** ☐ Aggregate
e ☐ Frozen initial liability **f** ☐ Individual level premium **g** ☐ Individual aggregate **h** ☐ Shortfall
i ☐ 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?		☐ Yes	☒ No
l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval?		☐ Yes	☐ 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	2.01 %	
		Pre-retirement	Post-retirement
b Rates specified in insurance or annuity contracts		☐ Yes ☐ No ☒ N/A	☐ Yes ☐ No ☒ N/A
c Mortality table code for valuation purposes:			
(1) Males	6c(1)	A	A
(2) Females	6c(2)	AF	AF
d Valuation liability interest rate	6d	7.50 %	7.50 %
e Expense loading	6e	15.0 % ☐ N/A	% ☒ N/A
f Salary scale	6f	% ☒ N/A	
g Estimated investment return on actuarial value of assets for year ending on the valuation date	6g		16.5 %
h Estimated investment return on current value of assets for year ending on the valuation date	6h		34.2 %

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	-2704635	-285024
4	-16934	-1785
5	-11428682	-1548835

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		☒ Yes ☐ No
b(2) Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule.		☒ Yes ☐ No
c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?		☐ Yes ☒ No
d If line c is "Yes," provide the following additional information:		
(1) Was an extension granted automatic approval under section 431(d)(1) of the Code?		☐ Yes ☐ No
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended	8d(2)	
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?		☐ Yes ☐ No
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	8d(4)	
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension	8d(5)	
(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?		☐ Yes ☐ No
e If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(s)	8e	

9 Funding standard account statement for this plan year:

Charges to funding standard account:

a Prior year funding deficiency, if any	9a		0
b Employer's normal cost for plan year as of valuation date	9b		3044876
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)	81796584	10234632
(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		995962
e Total charges. Add lines 9a through 9d	9e		14275470

	Credits to funding standard account:			
f	Prior year credit balance, if any		9f	**19077148**
g	Employer contributions. Total from column (b) of line 3		9g	**10712304**
		Outstanding balance		
h	Amortization credits as of valuation date	9h **34468634**		**5807209**
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h		9i	**2268041**
j	Full funding limitation (FFL) and credits:			
	(1) ERISA FFL (accrued liability FFL)	9j(1) **54151432**		
	(2) "RPA '94" override (90% current liability FFL)	9j(2) **20473723**		
	(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	**37864702**
m	Credit balance: If line 9l is greater than line 9e, enter the difference		9m	**23589232**
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference		9n	

9 o	Current year's accumulated reconciliation account:		
	(1) Due to waived funding deficiency accumulated prior to the 2021 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)	**0**
	(3) Total as of valuation date	9o(3)	
10	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)	10	**0**
11	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions		[X] Yes [ ] No

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

u File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public Inspection.

For calendar plan year 2021 or fiscal plan year beginning **05/01/2021** and ending **04/30/2022**

A Name of plan

MICHIGAN BAC PENSION FUND

B Three-digit plan number (PN) **u** **001**

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

MICHIGAN BAC PENSION FUND

D Employer Identification Number (EIN)

38-2895943

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions ..... | 1 |

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

EIN(s): _____ _____

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

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year ..... | 3 | **1**

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer **DAVENPORT MASONRY, INC**

b EIN **38-3113769** **c** Dollar amount contributed by employer **1446263**

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

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

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

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

a Name of contributing employer **LEIDEL & HART MASON CONTRACTOR**

b EIN **38-1903393** **c** Dollar amount contributed by employer **835070**

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

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

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

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

a Name of contributing employer **SCHIFFER MASON CONTRACTORS, INC.**

b EIN **38-2108378** **c** Dollar amount contributed by employer **623624**

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

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

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: [X] last contributing employer [ ] alternative [ ] reasonable approximation (see instructions for required attachment)	**14a**	**16**
b The plan year immediately preceding the current plan year. [ ] Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14b**	**16**
c The second preceding plan year. [ ] Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14c**	**16**

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

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	**1.00**
b The corresponding number for the second preceding plan year	**15b**	**1.00**

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

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
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**	

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

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

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

19 If the total number of participants is 1,000 or more, complete lines (a) through (c)

a Enter the percentage of plan assets held as:
Stock: **74.2** % Investment-Grade Debt: **18.2** % High-Yield Debt: _____ % Real Estate: **5.4** % Other: **2.2** %

b Provide the average duration of the combined investment-grade and high-yield debt:
[ ] 0-3 years [X] 3-6 years [ ] 6-9 years [ ] 9-12 years [ ] 12-15 years [ ] 15-18 years [ ] 18-21 years [ ] 21 years or more

c What duration measure was used to calculate line 19(b)?
[ ] Effective duration [X] Macaulay duration [ ] Modified duration [ ] Other (specify):

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

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? [ ] Yes [X] No

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

Funding Standard Account Worksheet

Form **5500**

For calendar year 2021, or tax year beginning **05/01/2021**, and ending **04/30/2022**

2021

Plan name
MICHIGAN BAC PENSION FUND

Three-digit plan number
001

Sponsor name
MICHIGAN BAC PENSION FUND

Employer identification number
38-2895943

9	Funding standard account statement for this plan year: **Charges to funding standard acct.:** **Total**			
a	Prior year funding deficiency, if any		9a	0
b	Employer's normal cost for plan year as of valuation date		9b	3,044,876
c	Amortization charges as of valuation date:	**Outstanding Balance**		
	(1) All bases except funding waivers	($ 81,796,584)	c(1)	10,234,632
	(2) Funding waivers	($)	c(2)	
	(3) Certain bases for which the amortization period has been extended	($)	c(3)	
d	Interest as applicable on lines 9a, 9b, and 9c		9d	995,962
e	Total charges. Add lines 9a through 9d		9e	14,275,470
	Credits to funding standard account:			
f	Prior year credit balance, if any		9f	19,077,148
g	Employer contributions. Total from column (b) of line 3		9g	
		Outstanding Balance		
h	Amortization credits as of valuation date	($ 34,468,634)	9h	5,807,209
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h		9i	2,268,041
j	Full funding limitation (FFL) and credits			
	(1) ERISA FFL (accrued liability FFL)	j(1) 54,151,432		
	(2) "RPA '94" override (90% current liability FFL)	j(2) 20,473,723		
	(3) FFL credit		j(3)	
k	**(1)** Waived funding deficiency		k(1)	
	(2) Other credits		k(2)	
l	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)		9l	27,152,398
m	Credit balance: If line 9l is greater than line 9e, enter the difference		9m	12,876,928
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference		9n	
	Reconciliation account:			
o	Current year's accumulated reconciliation account:			
	(1) Due to waived funding deficiency prior to current year	o(1)		
	(2) Due to amortization bases extended and amortized under section 6621(b):			
	(a) Reconciliation outstanding balance as of valuation date	o(2)(a)		
	(b) Reconciliation amount. Line 9c(3) balance minus line 9o(2)(a)	o(2)(b)		
	(3) Total as of valuation date		o(3)	

SCHEDULE MB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 05/01/2021 and ending 04/30/2022

▶ **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
Michigan BAC Pension Plan

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
Trustees of Michigan BAC Pension Pl

D Employer Identification Number (EIN)
38-2895943

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

1a Enter the valuation date: Month 5 Day 1 Year 2021

b	Assets		
(1)	Current value of assets	**1b(1)**	165,528,214
(2)	Actuarial value of assets for funding standard account	**1b(2)**	165,528,214
c (1)	Accrued liability for plan using immediate gain methods	**1c(1)**	193,779,016
(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)**	193,779,016
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)**	406,737,437
(b)	Expected increase in current liability due to benefits accruing during the plan year	**1d(2)(b)**	7,867,923
(c)	Expected release from "RPA '94" current liability for the plan year	**1d(2)(c)**	11,890,201
(3)	Expected plan disbursements for the plan year	**1d(3)**	12,009,698

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

Angela Jeffries

Signature of actuary

2-6-2023

Date

Angela L. Jeffries, FCA, EA, MAAA

Type or print name of actuary

20-08511

Most recent enrollment number

United Actuarial Services, Inc.

Firm name

(317) 580-8668

Telephone number (including area code)

11590 N. Meridian Street, Suite 610
Carmel IN 46032-4529

Address of the firm

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

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	**2a**		165,528,214
b "RPA '94" current liability/participant count breakdown:		**(1)** Number of participants	**(2)** Current liability
(1) For retired participants and beneficiaries receiving payment		885	164,142,692
(2) For terminated vested participants		859	98,510,709
(3) For active participants:			
(a) Non-vested benefits			5,063,384
(b) Vested benefits			139,020,652
(c) Total active		909	144,084,036
(4) Total		2,653	406,737,437
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	**2c**		40.70 %

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
4-30-2022	10,712,304				
			Totals ► **3(b)**	10,712,304	**3(c)** 0

(d) Total withdrawal liability amounts included in line 3(b) total — **3(d)** 0

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	**4a**	85.4 %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	**4b**	N

c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? ☐ Yes ☐ No

d If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? ☐ Yes ☐ No

e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	**4e**	
f If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here ☐	**4f**	

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

a ☐ Attained age normal **b** ☐ Entry age normal **c** ☒ Accrued benefit (unit credit) **d** ☐ Aggregate

e ☐ Frozen initial liability **f** ☐ Individual level premium **g** ☐ Individual aggregate **h** ☐ Shortfall

i ☐ 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? ☒ Yes ☐ No

l If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? ☒ Yes ☐ 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**	2.01 %
		Pre-retirement		Post-retirement	
b Rates specified in insurance or annuity contracts		☐ Yes ☐ No ☒ N/A		☐ Yes ☐ No ☒ N/A	
c Mortality table code for valuation purposes:					
(1) Males	**6c(1)**	A		A	
(2) Females	**6c(2)**	A		A	
d Valuation liability interest rate	**6d**	7.50 %		7.50 %	
e Expense loading	**6e**	15.0 %	☐ N/A	%	☒ N/A
f Salary scale	**6f**	%	☒ N/A		
g Estimated investment return on actuarial value of assets for year ending on the valuation date			**6g**	16.5 %	
h Estimated investment return on current value of assets for year ending on the valuation date			**6h**	34.2 %	

7 New amortization bases established in the current plan year:

(1) Type of base	**(2)** Initial balance	**(3)** Amortization Charge/Credit
1	-2,704,635	-285,024
4	-16,934	-1,785
5	-11,428,682	-1,548,835

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		☒ Yes ☐ No
b(2) Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule		☒ Yes ☐ No
c Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?		☐ Yes ☒ No
d If line c is "Yes," provide the following additional information:		
(1) Was an extension granted automatic approval under section 431(d)(1) of the Code?		☐ Yes ☐ No
(2) If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended	**8d(2)**	
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?		☐ Yes ☐ No
(4) If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2))	**8d(4)**	
(5) If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension	**8d(5)**	
(6) If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?		☐ Yes ☐ No
e If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(s)	**8e**	

9 Funding standard account statement for this plan year:

Charges to funding standard account:			
a Prior year funding deficiency, if any		**9a**	0
b Employer's normal cost for plan year as of valuation date		**9b**	3,044,876
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)**	81,796,584	10,234,632
(2) Funding waivers	**9c(2)**	0	0
(3) Certain bases for which the amortization period has been extended	**9c(3)**	0	0
d Interest as applicable on lines 9a, 9b, and 9c		**9d**	995,962
e Total charges. Add lines 9a through 9d		**9e**	14,275,470

Credits to funding standard account:				
f Prior year credit balance, if any			**9f**	19,077,148
g Employer contributions. Total from column (b) of line 3			**9g**	10,712,304
		Outstanding balance		
h Amortization credits as of valuation date	**9h**	34,468,634		5,807,209
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h			**9i**	2,268,041
j Full funding limitation (FFL) and credits:				
(1) ERISA FFL (accrued liability FFL)	**9j(1)**	54,151,432		
(2) "RPA '94" override (90% current liability FFL)	**9j(2)**	204,737,723		
(3) FFL credit			**9j(3)**	0
k (1) Waived funding deficiency			**9k(1)**	0
(2) Other credits			**9k(2)**	0
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)			**9l**	37,864,702
m Credit balance: If line 9l is greater than line 9e, enter the difference			**9m**	23,589,232
n Funding deficiency: If line 9e is greater than line 9l, enter the difference			**9n**	
9 o Current year's accumulated reconciliation account:				
(1) Due to waived funding deficiency accumulated prior to the 2020 plan year			**9o(1)**	0
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:				
(a) Reconciliation outstanding balance as of valuation date			**9o(2)(a)**	0
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))			**9o(2)(b)**	0
(3) Total as of valuation date			**9o(3)**	0
10 Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)			**10**	0
11 Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions				☒ Yes ☐ No