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 **09/01/2021** and ending **08/31/2022**

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 CARPENTERS' PENSION FUND

1b Three-digit plan number (PN) } **001**

1c Effective date of plan **08/06/1963**

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)
BOARD OF TRUSTEES, MICHIGAN CARPENTERS' PENSION FUND

6525 CENTURION DRIVE

LANSING MI 48917

2b Employer Identification Number (EIN) **38-6233978**

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			**TODD DOENITZ**
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			**MICHAEL BARNWELL**
	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**	**9678**
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)**	**3494**
a(2) Total number of active participants at the end of the plan year	**6a(2)**	**3379**
b Retired or separated participants receiving benefits	**6b**	**2807**
c Other retired or separated participants entitled to future benefits	**6c**	**2512**
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	**8698**
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	**888**
f Total. Add lines **6d** and **6e**	**6f**	**9586**
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**	**365**

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

1B

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

4H

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	**(1)** [ ] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	**(2)** [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	**(3)** [X] Trust
(4) [ ] General assets of the sponsor	**(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)** [X] **A** (Insurance Information) — **1**
- **(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 A (Form 5500)

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).

u File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning **09/01/2021** and ending **08/31/2022**

A Name of plan
MICHIGAN CARPENTERS' PENSION FUND

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

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, MICHIGAN

D Employer Identification Number (EIN)
38-6233978

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 Information:

(a) Name of insurance carrier

The Union Labor Life Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090		GA02096	0	09/01/2021	08/31/2022

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
0	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 whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	3294390

6 Contracts With Allocated Funds:

a State the basis of premium rates u

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	0
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	6d	

Specify nature of costs u

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☒ other (specify) u **Pension Benefits**

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here u ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other u

b	Balance at the end of the previous year			7b	
c	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)			
	u				
	(6) Total additions			7c(6)	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	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)			
	u				
	(5) Total deductions			7e(5)	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☐ Other (specify) **u**

9	Experience-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 reserve	9a(3)		
	(4) Earned ((**1**) + (**2**) - (**3**))		9a(4)	0
b	Benefit charges (1) Claims paid	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (**1**) and (**2**))		9b(3)	0
	(4) Claims charged		9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(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)	
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ 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)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)		9e	
10	Nonexperience-rated contracts:			
a	Total premiums or subscription charges paid to carrier		10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount		10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. **u**

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 **09/01/2021** and ending **08/31/2022**

A Name of plan	**B** Three-digit plan number (PN) **u**	
MICHIGAN CARPENTERS' PENSION FUND		**001**
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
BOARD OF TRUSTEES, MICHIGAN	**38-6233978**	

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

ABS INVESTMENT MANGEMENT
537 STEAMBOAR ROAD

GREENWICH CT 06830

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

AFL-CIO HOUSING INVESTMENT TRUST
2401 PENNSYLVANIA AVE, NEW STE. 200

WASHINGTON DC 20037

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

AG CORE PLUS REALTY FUND III, L.P.
245 PARK AVENUE, 26TH FLOOR

NEW YORK NY 10167

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

ARISTOTLE CAPITAL
ONE FEDERAL STREET, 36TH FLOOR

BOSTON MA 02110

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

BACKCAST PARTNERS
11726 SAN VICENTE AVENUE, STE 450

LOS ANGELES CA 90049

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

BLUE ROCK ADVISORS
445 EAST LAKE STREET, STE 120

WAYZATA MN 55391

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

BNY ASSET MANAGEMENT
201 WASHINGTON STREET

BOSTON MA 02108-4408

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

BPEA PRIVATE EQUITY
20 CUSTOM HOUSE STREET, STE 610

BOSTON MA 02110

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

CRESCENT CAPITAL GROUP, LP
11100 SANTA MONICA BLVD, STE 2000

LOS ANGELES CA 90025

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

ENTRUSTPERMAL PARTNERS OFFSHORE, LP
375 PARKE AVENUE 24TH FLOOR

NEW YORK NY 10152

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

GOLDENTREE ASSET MANAGEMENT
300 PARK AVENUE. 21ST FLOOR

NEW YORK NY 10022

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

GOLDPOINT PARTNERS
51 MADISON AVENUE

NEW YORK NY 10010

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

GROSVENOR CAPITAL MANAGEMENT, LP
900 NORTH MICHIGAN AVENUE, ST 1100

CHICAGO **IL 60611**

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

HARBORVEST PARTNERS, LLC
ONE FINANCIAL CENTER, 44TH FLOOR

BOSTON **MA 60611**

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

HARRISON STREET
444 WEST LAKE STREET

CHICAGO **IL 60606**

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

INTERCONTINENTAL REALL ESTATE CORP.
1270 SOLDIERS FIELD ROAD

BOSTON **MA 02135-1003**

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

JENNISON ASSOCIATE, LLC
466 LEXINGTON AVENUE, 18TH FLOOR

NEW YORK **NY 10017**

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

JP MORGAN ASSET MANAGEMENT **13-3980309**

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

KABOUTER INTENATIONAL OPPORTUNITIES
401 NORTH MICHIGAN AVENUE

CHICAGO **IL 60611**

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

KAYNE ADNERSON
811 MAIN STREET, 14TH FLOOR

HOUSTON **TX 77002**

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

LIGHTHOUSE PARTNERS
3801 PGA BOULEVARD, STE 500

PALM BEACH GARDENS FL 33410

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

LINDSELL TRAIN LTD
66 BUCKINGHAM GATE

LONDON
LONDON GB SW1E 6AU

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

LOOMIS SAYLES FUNDS
P.O. BOX 219594

KANSAS CITY MO 64121-9594

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

MESIROW
353 NORTH CLARK STREET

CHICAGO IL 60654

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

NATIONAL INVESTMENT SERVICES
777 E. WISCONSIN AVE, STE 2350

MILWAUKEE WI 53202

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

NEUBERGER BERMAN
1290 AVENUE OF THE AMERICAS

NEW YORK NY 10104

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

NEW TOWER TRUST COMPANY
3 BETHESDA METRO CENTER, STE 204

TROY MI 48098

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

NORTH SKY CAPITAL
33 SOUTH SIXTH SRREET, STE 4646

MINNEAPOLIS MN 55402

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

PRIVATE ADVISORS, LLC
901 EAST BYRD STREET

RICHMOND **VA 23219**

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

Prudential Financial **22-1211670**

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

RAINTREE CREDIT OPPORTUNITY
461 FIFTH AVENUE, 26 FLOOR

NEW YORK **NY 10017**

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

RBC GGLOBAL ASSET MANAGEMENT
227 W. MONROE ST

CHICAGO **IL 60608**

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

RIVERSTONE CREDIT PARTNERSHIP
712 FIRTH AVENUE, 36TH FLOOR

NEW YORK **NY 10019**

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

SCHRODER FUND ADVISORS, LLC
7 BRYANT PARK

NEW YORK **NY 10018-3706**

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

SEI TRUST COMPANY
100 CIDER MILL ROAD

OAKS **PA 19456**

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

SIGULER GUFF
200 PARK AVENUE, 23RD FLOOR

NEW YORK **NY 10166**

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

THE BANK OF NEW YORK MELLON
400 BELLEVUE PARKWAY

WILMINGTON **DE** **19809**

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

ULLICO INVESTMENT ADVISORS, INC
8403 COLESVILLE RD, 13TH FLOOR

SILVER SPRING **MD** **20910**

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

WALTER SCOTT & PARTNENRS **0**
ONE CHARLOTTE SQUARE

EDINBURGH
EDINGURGH **GB** **EH2 4DR**

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

WASHINGTON CAPITAL
260 FRANKLIN STREET, STE 1900

BOSTON **MA** **02110**

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

WILLIAM BLAIR
150 NORTH RIVERSIDE PLAZA

CHICAGO **IL** **60606**

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

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

(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 **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 38 15 13 10	NONE	678515	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

REINHART PARTNERS, INC. **39-1711628**

(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	237035	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

CLARKSTON CAPITAL **83-0473650**

(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	228101	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)

NEPC , LLC **83-0473650**

(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	201814	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JENNIFER MAGWOOD **38-6233978**

(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 30	EMPLOYEE OF THE FUND	88149	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(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	49362	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)

UNITED ACTUARIAL SERVCIES 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	49333	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

COMERICA BANK 38-6222545

(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	28035	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	27600	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)

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	25218	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JPMORGAN CHASE BANK
PO BOX 182051
COLUMBUS OH 43218-2051

(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 18	NONE	16555	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

UNION SERVICE AGENCY 38-3297465

(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?
53 22	NONE	0	Yes ☒ No ☐	Yes ☒ No ☐	11251	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)

STIFEL NICOLAUS & COMPANY
501 N. BROADWAY
ST. LOUIS MO 63102

(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?
71 33	NONE	10411	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PAYCHEX OF NEW YORK LLC 16-1470238

(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 49	NONE	9443	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PIPER JAFFRAY & CO
222 SOUTH NINTH STREET
Minneapolis MN 55402-3804

(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?
71 33	NONE	8490	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)

DBI BUSINESS INTERIORS
912 E. MICHIGAN AVENUE
LANSING MI 48912

(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**	**7340**	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MADIN HAUSER ROTH & HELLER, P.C. 38-3024220

(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**	**5787**	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 ☐

BOARD OF TRUSTEES, MICHIGAN 38-6233978

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 **09/01/2021** and ending **08/31/2022**

A Name of plan
MICHIGAN CARPENTERS' 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
BOARD OF TRUSTEES, MICHIGAN

D Employer Identification Number (EIN)
38-6233978

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: **SHORT TERM INVESTMENT TRUST**

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

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)
38-2217511 001	**C**	**6226820**

a Name of MTIA, CCT, PSA, or 103-12 IE: **MULTI EMPLOYER PROPERTY TRUST**

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

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)
52-6218800 001	**C**	**7213655**

a Name of MTIA, CCT, PSA, or 103-12 IE: **AFL-CIO HOUSING INVESTMENT TRUST**

b Name of sponsor of entity listed in (a): **PNC GLOBAL INVESTMENT**

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)
52-6220193 001	**C**	**3429956**

a Name of MTIA, CCT, PSA, or 103-12 IE: **SEPARATE ACCOUNT J**

b Name of sponsor of entity listed in (a): **THE UNION LABOR LIFE INSURANCE CO.**

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)
13-1423090 203	**P**	**3294390**

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

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

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)
27-6331814 010	**C**	**7922605**

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

Part II Information on Participating Plans (to be completed by DFEs)

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

a Plan name

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

a Plan name

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

a Plan name

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

a Plan name

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

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

a Plan name

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

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 09/01/2021 and ending 08/31/2022

A Name of plan

MICHIGAN CARPENTERS' PENSION FUND

B Three-digit plan number (PN) ▶ 001

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

BOARD OF TRUSTEES, MICHIGAN

D Employer Identification Number (EIN)

38-6233978

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	8,145,667	7,202,994
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	4,488,263	4,955,973
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	150,336	137,588
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(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)	0	
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	61,946,330	56,564,365
(5) Partnership/joint venture interests	1c(5)	249,869,703	259,228,447
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	24,419,765	24,793,036
(10) Value of interest in pooled separate accounts	1c(10)	3,263,153	3,294,390
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	276,249,771	209,156,869
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other See Statement 1	1c(15)	89,550,345	82,093,876

			(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	20,679	21,543
f	Total assets (add all amounts in lines 1a through 1e)	1f	718,104,012	647,449,081
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	1,563,731	1,527,204
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	501,193	994,425
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	2,064,924	2,521,629
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	716,039,088	644,927,452

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	54,471,887	
	(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)		54,471,887
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)	114,148	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		114,148
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)	718,545	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	123,092	
	(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		841,637
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	18,843,372	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	16,299,522	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		2,543,850
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)	-20,619,314	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		-20,619,314

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		-2,762,769
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		0
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-32,002,640
c Other income	2c		29,718
d Total income. Add all **income** amounts in column (b) and enter total	2d		2,616,517
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	70,235,879	
(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)		70,235,879
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)	526,419	
(2) Contract administrator fees	2i(2)	351,459	
(3) Investment advisory and management fees	2i(3)	2,166,102	
(4) Other	2i(4)	448,294	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		3,492,274
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		73,728,153
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-71,111,636
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		259228447
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 **462611**.

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 **09/01/2021** and ending **08/31/2022**

▶ **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 CARPENTERS' 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

BOARD OF TRUSTEES, MICHIGAN

D Employer Identification Number (EIN)

38-6233978

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

1a Enter the valuation date: Month **09** Day **01** Year **2021**

b Assets		
(1) Current value of assets	1b(1)	**716,039,088**
(2) Actuarial value of assets for funding standard account	1b(2)	**649,942,306**
c (1) Accrued liability for plan using immediate gain methods	1c(1)	**984,871,408**
(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)	**984,871,408**
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)	**2003747031**
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	**43,431,602**
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	**74,849,655**
(3) Expected plan disbursements for the plan year	1d(3)	**75,586,924**

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

04/21/2023

Signature of actuary — Date

Erika L. Creager, EA, MAAA — **20-07288**

Type or print name of actuary — Most recent enrollment number

United Actuarial Services, Inc. — **317-580-8675**

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**	716,039,088
b "RPA '94" current liability/participant count breakdown:	**(1)** Number of participants	**(2)** Current liability	
(1) For retired participants and beneficiaries receiving payment	3676	1063969029	
(2) For terminated vested participants	1955	291,481,716	
(3) For active participants:			
(a) Non-vested benefits		47,317,185	
(b) Vested benefits		600,979,101	
(c) Total active	3333	648,296,286	
(4) Total	8964	2003747031	
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage		**2c**	35.74 %

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
08/31/2022	54471887				
			Totals u 3(b)	54471887	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	66.0 %
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	E

c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? [X] 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** [X] 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	[X] 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:

			Pre-retirement	Post-retirement
a Interest rate for "RPA '94" current liability		6a	1.97 %	
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		9.1 % ☐ 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			10.8 %
h Estimated investment return on current value of assets for year ending on the valuation date	6h			21.5 %

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	-23818310	-2510056
4	1212360	127763

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)	5
(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	79323400

9 Funding standard account statement for this plan year:

		Outstanding balance	
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		14306831
c Amortization charges as of valuation date:			
(1) All bases except funding waivers and certain bases for which the amortization period has been extended	9c(1)	460407568	65497475
(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		5985321
e Total charges. Add lines 9a through 9d	9e		85789627

Credits to funding standard account:

f Prior year credit balance, if any		9f	83714709
g Employer contributions. Total from column (b) of line 3		9g	54471887
	Outstanding balance		
h Amortization credits as of valuation date 9h	41763757		4815381
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h		9i	868245
j Full funding limitation (FFL) and credits:			
(1) ERISA FFL (accrued liability FFL) 9j(1)	465423770		
(2) "RPA '94" override (90% current liability FFL) 9j(2)	1191193017		
(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	143870222
m Credit balance: If line 9l is greater than line 9e, enter the difference		9m	58080595
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 **09/01/2021** and ending **08/31/2022**

A Name of plan

MICHIGAN CARPENTERS' PENSION FUND

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

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

BOARD OF TRUSTEES, MICHIGAN

D Employer Identification Number (EIN)

38-6233978

Part I Distributions

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

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

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

EIN(s): _____ _____

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that 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
b EIN **c** Dollar amount contributed by employer
d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month Day Year
e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) ______
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

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

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

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

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

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**	**54**
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**	**49**
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**	**43**

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**	**1.10**
b The corresponding number for the second preceding plan year	**15b**	**1.26**

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: **49.3** % Investment-Grade Debt: **15.1** % High-Yield Debt: **0.5** % Real Estate: **6.6** % Other: **28.5** %

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 [ ] 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 **09/01/2021**, and ending **08/31/2022**

2021

Plan name
MICHIGAN CARPENTERS' PENSION FUND

Three-digit plan number
001

Sponsor name
BOARD OF TRUSTEES, MICHIGAN

Employer identification number
38-6233978

9	Funding standard account statement for this plan year:				
	Charges to funding standard acct.: **All Contractors**				
a	Prior year funding deficiency, if any			9a	0
b	Employer's normal cost for plan year as of valuation date			9b	14,306,831
c	Amortization charges as of valuation date:	**Outstanding Balance**			
	(1) All bases except funding waivers	($ 460,407,568)		c(1)	65,497,475
	(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	5,985,321
e	Total charges. Add lines 9a through 9d			9e	85,789,627
	Credits to funding standard account:				
f	Prior year credit balance, if any			9f	83,714,709
g	Employer contributions. Total from column (b) of line 3			9g	
		Outstanding Balance			
h	Amortization credits as of valuation date	($ 41,763,757)		9h	4,815,381
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h			9i	868,245
j	Full funding limitation (FFL) and credits				
	(1) ERISA FFL (accrued liability FFL)	j(1)	465,423,770		
	(2) "RPA '94" override (90% current liability FFL)	j(2)	1191193017		
	(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	89,398,335
m	Credit balance: If line 9l is greater than line 9e, enter the difference			9m	3,608,708
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)	

Federal Statements

MICHIGAN CARPENTERS' PENSION FUND

Plan: 001

Statement 1 - Form 5500, Schedule H, Line 1c(15) - Other Investments

Description	BOY Amount	EOY Amount
Hedge Fund of Funds	$ 89,550,345	$ 82,093,876
Total	$ 89,550,345	$ 82,093,876

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

Description	BOY Amount	EOY Amount
UNSETTLED INVESTMENT TRANS.	$ 501,193	$ 994,425
Total	$ 501,193	$ 994,425

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

Description	Amount
SECURITY LITIGATIONS	$ 20,287
LIQUIDATED DAMAGES COLLECTED	7,870
OTHER	1,258
SECURITY LENDING	303
Total	$ 29,718

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

Description	Amount
PBGC PREMIUMS	$ 251,007
TRUSTEE AND FIUCIARY INSURANCE	62,505
PRINTING AND MISCELLANEOUS	41,103
POSTAGE	32,808
BANK SERVICE CHARGES	18,957
MEMBER COMMUNICATIONS	18,891
CONFERENCE AND MEETING EXPENSE	9,287
DUES AND SUBSCRIPTIONS	6,000
PARTICIPANT NOTICES	4,716
MEDICAL EXAMINATIONS	3,020
Total	$ 448,294

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

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

Federal Statements

MICHIGAN CARPENTERS' PENSION FUND

Plan: 001

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

Name

Description	Purchase Price	Selling Price	Lease Rental	Expenses	Cost of Asset	Current Value	Net Gain or Loss
SEE ATTACHED FINANCIAL STATEMENT	$	$	$	$	$	$	$

Federal Statements

MICHIGAN CARPENTERS' PENSION FUND

Plan: 001

Statement 7 - Schedule MB, line 4c - Documentation Regarding Progress Under Funding Improvement or Rehabilitation Plan

Description
See attached progress under funding improvement.

Statement 8 - Schedule MB, line 11 - Justification for Change in Actuarial Assumptions

Description
See attached change in actuarial assumptions.

Federal Statements

MICHIGAN CARPENTERS' PENSION FUND

Plan: 001

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

Description	Date	Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount	Amortization Basis
All		$		$ 460,407,568		$ 65,497,475	Other

All Contractors

Statement 10 - Schedule MB, line 9h - Schedule of Funding Standard Account Bases

Description	Date	Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount
All		$		$ 41,763,757		$ 4,815,381
Total		$ 0		$ 41,763,757		$ 4,815,381