

Acknowledgement and General Information for Taxpayers Who File Returns Electronically

Thank you for taking part in the DOL EFAST-2 electronic filing program.

WESTERN STATES 401(k) RETIREMENT
5331 S MACADAM AVE STE 258
PORTLAND, OR 97239

- [X] Your federal annual tax return for tax year ending December 31, 2023 is being filed electronically with the DOL by the services of Iron Creek Tax & Consulting.
- [X] Your return was accepted by the DOL on 10/15/24 and the Return Acknowledgement Identification Number assigned to your return is 20241015121508NAL0028369009001.

Since you are filing your return electronically, PLEASE DO NOT SEND A PAPER COPY OF YOUR RETURN TO THE DOL. IF YOU DO, IT WILL DELAY THE PROCESSING OF THE RETURN.

Acknowledgement Process

The DOL will notify your electronic filer when they accept your return, usually within 24 hours of filing per the DOL electronic filing specifications. If your return was not accepted, the DOL will notify your electronic filer of the reasons for rejection.

If You Need to Make a Change to Your Return

If you need to make a change or correct the return you filed electronically, you may send an electronically filed amended Form 5500 or 5500-SF, Annual Return/Report of Employee Benefit Plan, to the DOL submission processing center.

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit PlanOMB Nos. 1210-0110
1210-0089**2023****This Form is Open to Public
Inspection****Part I Annual Report Identification Information**

For calendar plan year 2023 or fiscal plan year beginning _____ and ending _____

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide 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 _____ ►
D Check box if filing under: 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**WESTERN STATES 401(K) RETIREMENT FUND OF THE OPEIU****1b** Three-digit plan
number (PN) ► **001****1c** Effective date of plan
04/01/1959**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)

**WESTERN STATES 401(k) RETIREMENT
FUND OF THE OPEIU BOARD OF TRUSTEE****2b** Employer Identification
Number (EIN)
93-6026077**2c** Plan Sponsor's telephone
number
503-224-0048**2d** Business code (see
instructions)
561110**BENESYS, INC.**

5331 S MACADAM AVE STE 258

PMB# 116

PORTLAND OR 97239

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	Howard Bell Signature of plan administrator	10/14/2024	Howard Bell Trustee Enter name of individual signing as plan administrator
SIGN HERE	Howard Bell Signature of employer/plan sponsor	10/14/2024	Enter name of individual signing as employer or plan sponsor
SIGN HERE			Enter name of individual signing as DFE

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

Form 5500 (2023)

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor		3b Administrator's EIN
		3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:		4b EIN
a Sponsor's name		4d PN
c Plan Name		
5 Total number of participants at the beginning of the plan year		5 1683
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) 1477
a(2) Total number of active participants at the end of the plan year		6a(2) 488
b Retired or separated participants receiving benefits		6b 1042
c Other retired or separated participants entitled to future benefits		6c 75
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d 1605
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e 13
f Total. Add lines 6d and 6e		6f 1618
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		6g(1)
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g(2) 1618
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 82
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2J 2G 2T		
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)		9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance		(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts		(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust		(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor		(4) <input type="checkbox"/> 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		b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> I (Financial Information - Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>1</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____		(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)		(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)
		(6) <input type="checkbox"/> 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 2023 Form M-1 annual report. If the plan was not required to file the 2023 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).

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning

and ending

A Name of plan
WESTERN STATES 401 (K) RETIREMENT FUND OF THE OPEIU

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

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

D Employer Identification Number (EIN)

WESTERN STATES 401 (k) RETIREMENT

93-6026077

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

New York 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
13-5582869	66915	630500	102	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
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	2342880

6 Contracts With Allocated Funds:

a State the basis of premium rates ►

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

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

Specify nature of costs ►

6b	
6c	0
6d	

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

(3) other (specify) ►

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

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 ►

b Balance at the end of the previous year

7b

c Additions: (1) Contributions deposited during the year

7c(1)	
7c(2)	
7c(3)	
7c(4)	
7c(5)	

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

(5) Other (specify below)

►

(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

(2) Administration charge made by carrier

(3) Transferred to separate account

(4) Other (specify below)

►

(5) Total deductions

7e(1)	
7e(2)	
7e(3)	
7e(4)	

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)

7e(5)

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 organizations(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 <input type="checkbox"/> Health (other than dental or vision)	b <input type="checkbox"/> Dental	c <input type="checkbox"/> Vision	d <input type="checkbox"/> Life insurance
e <input type="checkbox"/> Temporary disability (accident and sickness)	f <input type="checkbox"/> Long-term disability	g <input type="checkbox"/> Supplemental unemployment	h <input type="checkbox"/> Prescription drug
i <input type="checkbox"/> Stop loss (large deductible)	j <input type="checkbox"/> HMO contract	k <input type="checkbox"/> PPO contract	l <input type="checkbox"/> Indemnity contract
m <input type="checkbox"/> Other (specify) ►			

9 Experience-rated contracts:

a Premiums: (1) Amount received
 (2) Increase (decrease) in amount due but unpaid
 (3) Increase (decrease) in unearned premium reserve
 (4) Earned ((1) + (2) - (3))

9a(1)	
9a(2)	
9a(3)	
	9a(4)

b Benefit charges (1) Claims paid
 (2) Increase (decrease) in claim reserves
 (3) Incurred claims (add (1) and (2))
 (4) Claims charged

9b(1)	
9b(2)	
	9b(3)
	9b(4)

c Remainder of premium: (1) Retention charges (on an accrual basis) --
 (A) Commissions
 (B) Administrative service or other fees
 (C) Other specific acquisition costs
 (D) Other expenses
 (E) Taxes
 (F) Charges for risks or other contingencies
 (G) Other retention charges
 (H) Total retention

9c(1)(A)	
9c(1)(B)	
9c(1)(C)	
9c(1)(D)	
9c(1)(E)	
9c(1)(F)	
9c(1)(G)	
	9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement
 (2) Claim reserves
 (3) Other reserves

9c(2)	
9d(1)	
9d(2)	
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
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.

10a	
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. ►

**SCHEDULE C
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

OMB No. 1210-0110

2023**This Form is Open to Public
Inspection.**

For calendar plan year 2023 or fiscal plan year beginning

and ending

A Name of plan**WESTERN STATES 401 (K) RETIREMENT FUND OF THE OPEIU****B** Three-digit
plan number (PN) ► **001****C** Plan sponsor's name as shown on line 2a of Form 5500**WESTERN STATES 401 (k) RETIREMENT****D** Employer Identification Number (EIN)**93-6026077****Part I Service Provider Information (see instructions)**

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions). Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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(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)

BeneSys, Inc. 38-2383171
5331 S MACADAM VE STE 528
PORTLAND OR 97239

(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?
	THIRD PARTY ADMIN.	106668	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Bjorklund & Montplaisir 93-1015766
10300 SW GREENBURG RD 470
Portland OR 97223

(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?
	AUDITOR	21200	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Withum 52-2385296
5331 S. Macadam Ave. 258
Portland OR 97239

(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?
	Payroll Auditor	31378	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a 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)

MONDRESS MONACO PARR LOCKWOOD 91-1917286
2101 FOURTH AVE, #2170
SEATTLE WA 98121

(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?
	LEGAL COUNSEL	33773	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

John Hancock Retirement Plan Svrcs 01-0233346
690 Canton Street
Westwood MA 02090

(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?
	RECORDKEEPER	209817	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

VERUS ADVISORY, INC. 91-1320111
PO BOX 303
Tualatin OR 97062

(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?
	INVESTMENT ADVISOR	53750	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Part III **Termination Information on Accountants and Enrolled Actuaries (see instructions)**
(complete as many entries as needed)

a Name: BJORKLUND & MONTPLAISIR	b EIN: 93-1015766
c Position: Accountant	
d Address: 6650 SW REDWOOD LD #210 PORTLAND OR 97224	e Telephone: 503-443-1040

Explanation: **BJORKLUND & MONTPLAISIR WAS ACQUIRED BY PLATFORM CPAS ON NOVEMBER 29, 2023.**

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 ServiceDepartment of Labor
Employee Benefits Security Administration**DFE/Participating Plan Information**

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

► File as an attachment to Form 5500.

OMB No. 1210-0110

2023**This Form is Open to Public Inspection.**

For calendar plan year 2023 or fiscal plan year beginning

and ending

A Name of plan**B** Three-digit plan number (PN) ► **001****WESTERN STATES 401(K) RETIREMENT FUND OF THE OPEIU****C** Plan or DFE sponsor's name as shown on line 2a of Form 5500**D** Employer Identification Number (EIN)**WESTERN STATES 401(k) RETIREMENT**

93-6026077

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: **New York Life Anchor Account IV****b** Name of sponsor of entity listed in (a): **New York Life Insurance Company****c** EIN-PN **13-5582869 125** **d** Entity code **P** **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) **2342880****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, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

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).

► File as an attachment to Form 5500.

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning

and ending

A Name of plan

B Three-digit
plan number (PN)

► 001

WESTERN STATES 401(K) RETIREMENT FUND OF THE OPEIU

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

D Employer Identification Number (EIN)

WESTERN STATES 401(k) RETIREMENT

93-6026077

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	133,722
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1)	122,326
(2) Participant contributions	1b(2)	107,873
(3) Other	1b(3)	8,453
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)	
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	227,492
(9) Value of interest in common/collective trusts	1c(9)	220,793
(10) Value of interest in pooled separate accounts	1c(10)	2,590,224
(11) Value of interest in master trust investment accounts	1c(11)	2,342,880
(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)	53,835,726
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	62,007,076
(15) Other	1c(15)	

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

Schedule H (Form 5500) 2023

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities			
(2) Employer real property			
e Buildings and other property used in plan operation			
f Total assets (add all amounts in lines 1a through 1e)		57,025,816	64,988,301
Liabilities			
g Benefit claims payable			
h Operating payables		34,515	14,509
i Acquisition indebtedness			
j Other liabilities			
k Total liabilities (add all amounts in lines 1g through 1j)		34,515	14,509
Net Assets			
l Net assets (subtract line 1k from line 1f)		56,991,301	64,973,792

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 Contributions:**

(1) Received or receivable in cash from: (A) Employers

(B) Participants

(C) Others (including rollovers)

(2) Noncash contributions

(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)

	(a) Amount	(b) Total
2a(1)(A)	1,645,782	
2a(1)(B)	1,170,657	
2a(1)(C)	18,702	
2a(2)		
2a(3)		2,835,141

b Earnings on investments:

(1) Interest:

(A) Interest-bearing cash (including money market accounts and certificates of deposit)

(B) U.S. Government securities

(C) Corporate debt instruments

(D) Loans (other than to participants)

(E) Participant loans

(F) Other

(G) Total interest. Add lines 2b(1)(A) through (F)

(2) Dividends: (A) Preferred stock

(B) Common stock

(C) Registered investment company shares (e.g. mutual funds)

(D) Total dividends. Add lines 2b(2)(A), (B), and (C)

(3) Rents

(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds

(B) Aggregate carrying amount (see instructions)

(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result

(5) Unrealized appreciation (depreciation) of assets: (A) Real estate

(B) Other

(C) Total unrealized appreciation of assets.

Add lines 2b(5)(A) and (B)

2b(1)(A)		
2b(1)(B)		
2b(1)(C)		
2b(1)(D)		
2b(1)(E)		
2b(1)(F)		
2b(1)(G)		0
2b(2)(A)		
2b(2)(B)		
2b(2)(C)	1,839,449	
2b(2)(D)		1,839,449
2b(3)		
2b(4)(A)		
2b(4)(B)		
2b(4)(C)		0
2b(5)(A)		
2b(5)(B)		
2b(5)(C)		

(6) Net investment gain (loss) from common/collective trusts	
(7) Net investment gain (loss) from pooled separate accounts	
(8) Net investment gain (loss) from master trust investment accounts	
(9) Net investment gain (loss) from 103-12 investment entities	
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	
c Other income	
d Total income. Add all income amounts in column (b) and enter total	

	(a) Amount	(b) Total
2b(6)		
2b(7)		84,412
2b(8)		
2b(9)		
2b(10)		7,557,018
2c		119,115
2d		12,435,135

Expenses

e Benefit payment and payments to provide benefits:

(1) Directly to participants or beneficiaries, including direct rollovers	
(2) To insurance carriers for the provision of benefits	
(3) Other	
(4) Total benefit payments. Add lines 2e(1) through (3)	

f Corrective distributions (see instructions)

g Certain deemed distributions of participant loans (see instructions)

h Interest expense

i Administrative expenses:

(1) Salaries and allowances	
(2) Contract administrator fees	
(3) Recordkeeping fees	
(4) IQPA audit fees	
(5) Investment advisory and management fees	
(6) Bank or trust company trustee/custodial fees	
(7) Actuarial fees	
(8) Legal fees	
(9) Valuation/appraisal fees	
(10) Other trustee fees and expenses	
(11) Other expenses	
(12) Total administrative expenses. Add lines 2i(1) through (11)	

j Total expenses. Add all **expense** amounts in column (b) and enter total

2e(1)	3,915,832	
2e(2)		
2e(3)		
2e(4)		3,915,832
2f		
2g		
2h		
2i(1)		
2i(2)	316,485	
2i(3)		
2i(4)	52,578	
2i(5)	53,750	
2i(6)		
2i(7)		
2i(8)	33,773	
2i(9)		
2i(10)		
2i(11)	80,226	
2i(12)		536,812
2j		4,452,644

Net Income and Reconciliation

k Net income (loss). Subtract line **2j** from line **2d**

l Transfers of assets:

(1) To this plan	
(2) From this plan	

2k		7,982,491
2l(1)		
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) Unmodified (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) 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: **BJORKLUND & MONTPLAISIR**

(2) EIN: **93-1015766**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG 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. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

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.)

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.)

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.)

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.)

e Was this plan covered by a fidelity bond?

f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?

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?

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?

i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)

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.)

k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?

l Has the plan failed to provide any benefit when due under the plan?

m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)

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.

	Yes	No	Amount
4a	X		5032
4b		X	
4c		X	
4d		X	
4e	X		500000
4f		X	
4g		X	
4h		X	
4i	X		
4j		X	
4k		X	
4l		X	
4m		X	
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 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 _____.

Federal StatementsFYE: 12/31/2023 **WESTERN STATES 401(K) RETIREMENT FUND OF THE OPEIU**
Plan: 001**Statement 1 - Form 5500, Schedule H, Line 2c - Other Income**

Description	Amount
Service Credits	\$ 113,617
Liquidated Damages	5,498
Total	\$ <u>119,115</u>

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

Description	Amount
Meetings	\$ 20,960
Office	6,861
Insurance	52,405
Total	\$ <u>80,226</u>

Statement 3 - Schedule H, Line 4i - Schedule of Assets Held for Investment

Party in Interest	Identity	Description	Cost	Current Value
	SCHEDULE ATTACHED		\$	\$

Form 5500		Electronic Filing - PDF Attachment Report		2023
For calendar year 2023, or tax year beginning WESTERN STATES 401(k) RETIREMENT FUND OF THE OPEIU BOARD OF TRUSTEE		, and ending		Taxpayer Identification Number 93-6026077
Title	Attachment Source			Proforma
Federal Attachments:				
Schedule H: Schedule of Assets (Held at End of Year)	FileCabinet CS: 23 WS401K ASSETS.PDF			No
Schedule H: Delinquent Participant Contributions	FileCabinet CS: 23 WS401K DELINQUENT PARTICIPANT CONTRIB.PDF			No
Other Attachment	FileCabinet CS: 23 WS401K FINANCIALS.PDF			No
Schedule H and I: IQPA report (Accountant Opinion)	FileCabinet CS: 23 WS401K OPINION.PDF			No
Manually signed Form 5500 or 5500-SF under e-signature option for service providers	FileCabinet CS: 23 WS401K MANUALLY SIGNED 5500.PDF			No